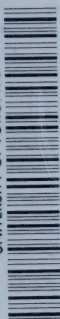


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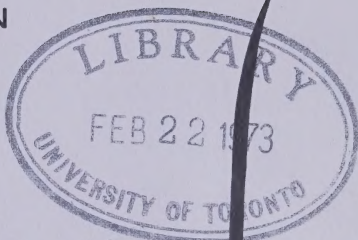
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SUMMER 1967

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Journal

SUMMER 1967

Table of Contents

1. Past-President's Address
2. President's Address
3. Scientific News
 - a) New Therapy for Periodontal Disease
 - b) Evaluation of Super Stripe Toothpaste
 - c) Study on Fact toothpaste
 - d) Summary on the Royal Commission on Health Services pertaining to Dental Auxiliaries.
 - e) B. C. D. H. A. Post-Graduate Course
 - f) Post-Graduate Radiography Course at Ann Arbor, Michigan.
4. Report of the C. D. H. A. Executive and Committees, 1966-67
5. Minutes of the Annual Session, May 14 - 17, 1967.

PAST-PRESIDENT'S ADDRESS

It is an honour to belong to a Professional Association! The hygienist does not work to better her personal interests but rather to contribute to the health of her community, who respects and values her services. The objectives of our professional association, the C. D. H. A., expand on this theme -- "...to cultivate, promote, and sustain the art and science of Dental Hygiene, to maintain the honour and interests of the Dental Hygiene Profession; to represent and safeguard the common interests of the members of the profession and in so doing contribute toward the improvement of the health of the public". It has always been the aim of your Executive, Committees, and Boards of Directors to fulfill these terms in their broadest sense. They have spent endless hours and energy in establishing a firm, purposeful, national Association.

We are a young but significant part of the dental profession. Naturally our provincial organizations, because of their convenience and familiarity are of immediate interest and can command our loyalty and membership. A widespread group that meets only annually and then probably in some distant part of Canada cannot hope to demand the same degree of enthusiasm. Such mammoth proposals as provincial and national health schemes, however, compel all health services to be prepared to speak in an informed and intelligent manner on national as well as local problems and perhaps with very little warning. The C. D. H. A. officially represents the members of the Dental Hygiene profession to the Canadian Dental Association, the Federal government, the British and American Dental Hygiene Associations. The C. D. H. A. is also striving to attain those striking attributes such as scholarships, scientific meetings, more effective and less expensive national insurance plans, national hygiene exams, the publishing of informative material for the public and prospective hygiene students, and the means to increase our own knowledge, such as this Journal.

Our prime concern should be to provide a means to communicate with each other on scientific news and ideas. Continuing research and ever expanding knowledge are of little value without communication. It is hoped that this Journal will serve this purpose effectively and that you will be encouraged to contribute to its success. The position of Editor carries a great responsibility to the Canadian Dental Hygiene profession.

I am grateful for this opportunity to address you as your Canadian Past-President and on behalf of the Executive, to extend our best wishes for the holiday season and the coming year - to you personally, and for success in your constituent association activities.

Yours sincerely,

(Miss) Bonnie V. A. Snowdon,
Past-President.

PRESIDENT'S ADDRESS

It has been a great honor to have been elected to serve as President of the Canadian Dental Hygienists' Association for 1967-68. Our profession and our Association have reached an important stage in its history, and as your President, I need your support individually, and through your Constituent Associations to make the next year one of forward growth.

A dentist was the parent of our profession, and dentistry will continue to determine the new avenues of progress in expanded duties, but we need a voice and a strong voice to speak for all the hygienists in Canada in this matter. So as I prepare to accept the responsibilities of the office of President for the coming year, I ask you to accept the obligation of being a working, interested member in your Professional Association.

Look at your meetings - who attends, who speaks

Look at your Organization - who directs

Look at your future - who guides

We must continue forward and not allow the work and effort of those before us to be lost. The time and effort spent by the Past-Presidents, Bonnie Snowdon, Dixie Scoles, Jill Dosset and Mae Pollack set an example for me to follow. You have my assurance that I will work equally hard for you and the Canadian Dental Hygienists' Association.

Jo Gardner, President
C. D. H. A.

NEW THERAPY FOR PERIODONTAL DISEASE:

Freezing Technique Seen Replacing Gingivoplasty

Dental Times (The American Dental Association Newsletter),
Vol. 9 No. 10, October 15, 1966

A periodontist has developed a technique for treating periodontal disease in its early stages by freezing the inflamed tissue to minus 75 degrees C. During healing of the resulting lesion, the tissue shrinks into a more desirable contour.

The stages of the therapy are:

- 1) subgingival scaling of root surfaces two weeks before cryotherapy (the freezing technique)
- 2) application of instrument to papillary gingiva at a temperature of -75 degrees C.
- 3) formation of ice balls instantly, melting in between 10 to 15 seconds
- 4) gingiva tissue shrinkage and pocket size reduction

Designed to replace gingivoplasty, cryotherapy is most effective in reducing the bulbous contour in fibrotic tissue and shows promise as a method of reducing pocket depth without surgical intervention, said Dr. Ronald Odrich.

Dr. Odrich, an instructor in periodontics at Columbia University School of Dental and Oral Surgery, reported on his use of the supercold technique in 50 patients at a meeting of the Society for Cryobiology in Boston recently.

The freezing technique was first used to reseat detached eye retina tissue in 1962 by Dr. Kelman, an ophthalmologist. The same principle applies when used either on the eye or the gingiva. An exudative inflammatory lesion is induced as a result of freezing the affected area. Adhesion and shrinkage of the tissue is achieved.

The intriguing prospects of treatment of periodontal disease by this method encouraged Dr. Odrich to conduct preliminary animal experiments using histologic evidence based on 100 lesions produced in the animals. He reported no significant damage to the tissue underlying bone.

In his clinical study with 50 private patients, Dr. Odrich used an instrument especially designed for him. It is composed of a source of a refrigerant (freon) which is delivered through a tube to a cryostylet.

Sixty-four lesions were produced by applying the tip of the cryostylet to the papillary gingivae, using temperatures that ranged from -35 to -75 degrees. Applications were for one minute each in most cases and repeated once in all cases. In each patient, a thorough subgingival scaling of the root surfaces was carried out several weeks before the

freezing phases. Pockets were measured before and two months after the use of cryotherapy. They ranged in depth from four to 10 mm. before treatment.

Those applications which resulted in three or more mm. of pocket reduction were considered successful. The average of 20 such lesions was 3.15 mm. of pocket reduction. Applications which yielded less than two mm. of pocket reduction were considered unsuccessful. The average of 44 such applications resulted in 1.02 mm. reduction of depth.

In one instance, there was a dramatic reduction of eight mm. of pocket depth, from 10 down to two mm., as a result of cryotherapy. "This would seem to indicate," said Dr. Odrich "that given the proper conditions (temperature, depth of penetration, rate of cool and thaw, time of application), such results are possible without drastically changing the level of the gingivae by excisional techniques.

"Another factor worthy of mention is that without exception, every patient treated with cryotherapy was able to tolerate the treatment without the use of the usual local anaesthesia. The most anxious patients tolerated the cryotherapy with no complaint and voluntarily characterized their subjective sensations as a low grade discomfort."

Varying types of lesions can be produced by cryotherapy, ranging from a mild erythematous papule to a necrotic, sloughing wound, depending upon the temperature and duration of application. Ideally, Dr. Odrich said, the values of choice would produce enough of an exudative response in the corium layer to stimulate shrinkage and adhesion during the repair phase and at the same time cause the overlying epithelium to slough, thereby facilitating adhesion.

Further experimentation, he said, will yield the information needed to make the cryosurgical approach a clinically predictable therapeutic modality.

EVALUATION OF SUPER STRIPE TOOTHPASTE: COUNCIL ON DENTAL THERAPEUTICS

The Council on Dental Therapeutics has carefully reviewed the laboratory and clinical data submitted by Lever Brothers Company in support of the effectiveness of its stannous fluoride dentifrice, Super Stripe, as a product for home use in the partial prevention of dental caries and has classified the dentifrice in Group B.

The Super Stripe formulation contains 0.4 per cent stannous fluoride, 41.0 per cent insoluble sodium metaphosphate, 5.0 per cent calcium pyrophosphate and other regular ingredients.

The manufacturer has supplied data from a clinical study of 2 years' duration which was conducted on a group of schoolchildren ranging in age from 7 to 12 years. The study involved two well-balanced groups of approximately 300 children each. The investigators compared the clinical caries experience of a group using the test dentifrice with a similar group using the test dentifrice with a similar group using the control dentifrice. Both groups had supervised classroom brushing once a day during the school term.

The 2-year data indicate a significant reduction in the incidence of dental caries when compared with the placebo dentifrice. Based on increments in decayed or filled surfaces, the 2-year results indicate approximately a 19 per cent reduction.

It should be noted that the trade name, Stripe, has been applied previously to a nonfluoride dentifrice. That product will be replaced by the new stannous fluoride formulation, which will be designated as Super Stripe in order to distinguish it from the earlier formulation. Consumer advertising for Super Stripe will not appear until the new product has been supplied to retail outlets. (Note: article written in June, 1966)

The Journal of the American Dental Association, June 1966, Vol. 72, No. 6, P. 1515.

COMPARATIVE STUDY OF A FLUORIDE DENTIFRICE CONTAINING SOLUBLE PHOSPHATE AND A CALCIUM FREE ABRASIVE ('FACT' TOOTHPASTE): SECOND YEAR REPORT¹.

Five dentifrices were assigned to five groups of children, ranging in age from 10 to 19 years. After 2 years of unsupervised, permissive toothbrushing at home, the group that used a FLUORIDE * PHOSPHATE CALCIUM-FREE dentifrice had significantly lower increments of DFT (decayed, filled teeth), DFS, DMFT, and DMFS than the group that used a fluoride-free dentifrice and a significantly lower increment of DMFS than the group that used another anticaries toothpaste containing stannous fluoride and calcium pyrophosphate.

The A. D. A. Council on Dental Therapeutics has classified Fact toothpaste in Group B, after review of the laboratory and clinical data submitted by the Bristol-Myers Company in support of the dentifrice.²

(No mention was made in the report about the bleaching action emphasized in Fact advertisements. The article also did not report the actual per cent reduction in the incidence of tooth decay with the phosphate fluoride and calcium free abrasive dentifrice)

¹ The Journal of the American Dental Assoc., April 1966, Vol. 72 p. 889, by Brudevold and Chilton

² Federation Dentaire Internationale Newsletter, No. 53, January 1966.

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DENTAL AUXILIARIES

DENTAL HYGIENISTS

Summary on The Royal Commission on Health Services

volume 1 1964

(C. H. McCormick)

p. 75 DENTAL AUXILIARIES

The increase in dentists resulting from the above recommendations will be of some help, but will not by any means meet our full needs. The Commission is convinced that it is now necessary to introduce a large scale training program to train dental auxiliaries who will be employed solely in the Children's Dental program, and who will work under the direct supervision of dentists.

We recognize that there may be some temporary opposition, both inside and outside the profession, but the evident deplorable state of dental health in this country, combined with the scarcity of dentists, the scarcity of qualified professors of dentistry, and the time required to develop new dental schools, make emergency action imperative. Furthermore, the measures we propose have been successful in New Zealand, and are being experimented with and studied in Great Britain. We are confident that we can develop a successful program in Canada, and those that are concerned with the dental health of our children will support the proposal to the full.

The proposal is to train dental auxiliaries who are qualified to repair cavities, and place fillings in teeth of children, under strict pre-clinical and clinical supervision. They would also be qualified in dental health education and enable to give instruction to patients in self-care.

- p. 76 It is essential that they be licensed to practice only under the supervision of a licenced dentist, and be limited to practice only in the Children's Dental Program.

These auxiliaries can be trained in two years, as both the New Zealand and United Kingdom experience indicate. They can be trained in a special program provided by a dental school in adjacent quarters or in an institution of technology, supervised by a dental school faculty, and accredited by the dental auxiliary advisory committee that we recommend.

- p. 76 On the basis of our estimated, it will be necessary to have available at least 1,000 such qualified auxiliaries in January, 1968, if the Children's Dental program is to begin in that year

on a national basis, and to increase the number graduated each year to 15,000 in 1971. Since, in order to graduate these auxiliaries by 1968, it will be necessary to enroll the first class by 1965, no time must be lost in organizing the educational program for these auxiliaries.

The Commission recommends: -

Item 168 -- that a Dental Auxiliary Advisory Training Committee be appointed to the Department of National Health and Welfare, consisting, among others, of representatives of the Canadian Dental Association, the Provincial Dental Colleges or Boards, the National Dental Examining Board, Canadian Dental Schools, Dominion Council of Health, the Association du Medicine du Langue du Francais Canada, the Canadian Medical Association (Pediatrics Section) and of Canadian women, together with the Director of the Dental Health Division, Department of National Health and Welfare.

Item 169 -- that this body, together with the Deans of the dental schools develop a curriculum which will qualify the auxiliaries in a two year program.

Item 170 -- that the dental auxiliaries be qualified to prepare cavities and place fillings in the teeth of children, under strict clinical and pre-clinical supervision, and to undertake dental health education and give instructions to patients in self-care.

Item 171 -- that dental auxiliaries be paid an adequate salary in order to attract a sufficient number of applicants.

Item 172 -- that the Federal Government provide grants to dental schools and/or technical schools to provide the equipment and installation and provide the professional faculty acquired to establish the educational programs beginning in 1966, to train a minimum of 1,000 dental auxiliaries per year. Technical schools should also be assisted to establish courses for the preparation of dental technicians and dental assistants.

Item 173 -- that the Professional Training Grant and the Technical and Vocational Training Grant be increased to provide bursaries to registrants to meet the cost of tuition, books, and maintenance.

The Federal Government now provides grants to universities equal to two dollars per capita of each province's population.

78 Item 175 -- that the Federal Government establish a ten year capital development budget to assist in the provision of medical, dental, public health, nursing, and other health professions, educational facilities, (including medical schools, dental schools, schools of public health, schools of

nursing, basic science buildings and equipment). The fund should be called, The Health Facilities Development Fund, and should incorporate the present Hospitalization Construction Grant. (Dental Services Item 40 and 46.)

p. 94 Schools for Dental Auxiliaries

By 1968, between 7 and 10 new schools must be established to train dental auxiliaries.

The growing confidence in modern medicine and health institutions generally, is motivating more people to seek health care, sometimes perhaps even to the extent of making excess demands for services.

- p. 209 There seems to be an attitude toward dental care as something more elective than general health care, partly due perhaps to a lack of awareness of its nature, the limited access to care facilities, and their costs.

- p. 210 The available evidence is convincing that dental disease is one of the most frequent health defects found in the community.

Canadian children 7 - 13 years of age ... 13% no defects
... 21% no caries defects
... backlog of 3.4 teeth
 per child up to 14 years
... backlog of 2.9 teeth
 per adult

- p. 211 Despite this great need for dental services, the effective demand is very low. One in seven Canadians visited a dentist during a year (C. S. Survey 50-51). One third of all Canadians received some care in a year.

There are considerable differences among income groups in the frequency of dental visits. Four times as many children, (under 15), in the high (upper) income groups, as in the low income groups received dental care.

The high expenditure for dental services, even though these services are inadequate at the present utilization rate, is noteworthy.

p. 283 PARA DENTAL PERSONNEL

Dental Hygienist

- female occupation requiring university training.
- "The subject matter covered in the course ranges through the social sciences, the humanities, public speaking, the

biological sciences, and clinical and laboratory courses. Whether studies in such a wide range of subjects or a course of two year's duration is necessary in order to prepare for the duties of a hygienist, is a debatable point." (See Chapter 13).

-- "The duties of a hygienist are defined by law, but what she actually does under the supervision of her employer is determined, to a large extent, by his attitudes towards hygienists as a professional group in the practice of dentistry, and by the demands made upon him by his patients."

p. 284 Formal Duties: --

1. Professional -- clinical service
2. Technical -- mechanical
3. Clerical -- administrative
4. Educational

p. 284 Professional-clinical services is defined in the Provincial Legislation governing the professional activities of the Hygienist. This includes -- dental prophylaxis -- the scaling and polishing of the patients' teeth; the application of topical fluorides; and "taking of impressions of the mouth from which artificial dentures can be made." The technical-mechanical functions include the taking and mounting of dental x-rays, the cementing and facing of pontics, and making minor adjustments to prosthetic appliances. The clerical-administrative duties involve those office procedures which make the administrative aspects of the practice of dentistry more efficient. The educational function includes teaching individual patients and the public at large the proper care of teeth -- the total number graduated in the last dozen years indicate that few dentists make use of this type of auxiliary service.

p. 285 Dental Assistants

Although few dentists employ dental hygienists, a large proportion employ dental assistants, of which there were approximately 4,700 full time, 300 part-time in 1962. These assistants are of two types: the secretary-receptionist and the chairside assistant. The majority have had no formal training for their duties, although they have been given on-the-job-training. The others have received some kind of formal training as a dental assistant, dental nurse, dental hygienist or registered nurse.

p. 285 Dental Technicians

The dental technician undertakes "... extra-oral technical services involved in the fabrication of prosthesis and appliances on the basis of written prescriptions from the dentist. This separation of certain technical functions from the professional role of the dentist has led to problems of the control of the technician by the dentists. In some provinces,

dental technicians have tried to deal directly with the public, rather than through the dentists, but only in Alberta have they been given this right. Most of the technicians trained in Canada learned their skills through on-the-job-training with a technician already in practice. Some provincial associations have organized part-time and evening classes for dental technician trainees.

- p. 286 Surveys conducted by the Canadian Dental Association have shown that average net income is related to the number of dental chairs and the employment of assistants, one working as a chair-side assistant and one working as a secretary-receptionist. With this overhead, the dentists' net income is about 50% of gross income. (Table 7-30).

Dental Auxiliaries.

In New Zealand a programme of dental services for children has relied upon the school dental nurse to increase the supply of dental services. These dental nurses are trained and employed by the Department of Health, which is responsible for the school dental clinics. Since this training has met with some success, we think a discussion of some aspects of its operation may be helpful.

Girls over 17 years of age holding a school certificate, which is not equivalent to university entrance, are recruited for a two year programme. Of the total of 1,608 training hours, the student spends 284 hours in the first year, and 784 hours in the second year. In the first year, lectures take up 36% of the time, and laboratory instruction 64%. In the second year, 11% of the time is spent in lectures, and 89% in clinical instruction and practice. On successful completion of the course, the school dental nurse working under the direction of a dentist, may perform, "... examinations, prophylaxis, fillings, extractions, gum treatments and dental health education for elementary school children."

In the United Kingdom under the Dentist Act, 1957, and in accordance with the General Dental Council, the dental auxiliaries are given responsibilities similar to those of the New Zealand School Dental Nurses; and --

- (3) "subject to the provision of these regulations, a dental auxiliary shall be permitted to carry out all dental work amounting to the practice of dentistry of the following kind;
- (a) extracting deciduous teeth, under local infiltration anaesthesia;
 - (b) undertaking simple dental fillings;
 - (c) cleaning and polishing teeth;
 - (d) scaling, that is to say, the removal of tartar, deposits, accretions and stains from those parts of the recesses of the teeth, which are exposed and which

are directly beneath the free margins of the gums, including the application of medicants appropriate thereto;"

(e) The application to the teeth of solutions of sodium or stannous fluoride, or just other similar prophylactic solutions as the Council may from time to time determine;

(f) Giving advice within the meaning of sub-section (1) of Section 33 of the Dentist Act, 1967), such as may be necessary to the proper performance of the dental work referred to in its regulation, and on matters relating to oral hygiene; but shall not be permitted to carry out dental work amounting to the practice of dentistry of any other kind.

- p. 288 (4) "A dental auxiliary shall not be permitted to carry out dental work amounting to the practice of dentistry, except: -
- (a) in the course of providing national or local authority health services;
 - (b) under the direction of a registered dentist;
 - (c) after the registered dentist has examined the patient, and has indicated to the auxiliary the specific treatment to be provided for the patient by the said auxiliary. "

The two programmes, although one is still in the experimental stage, provide evidence that auxiliary personnel can be recruited and trained to undertake many of the routine functions of the dentists.

p. 293 Population per dentist:

1901	1/4, 100
1921	1/2, 783
1941	1/2, 733
1961	1/3, 047

- p. 569 The work carried out by these technicians is more intensive in some respects than that undertaken by the civilian Dental Hygienist, even the former are not graduates of a two year University Course. In fact the minimum educational requirements required to enlist in the Canadian Army is Grade VIII, although, of course, many recruits will exceed this minimum. Nevertheless, the fact remains that highly skilled technicians are trained outside the University to perform dental treatment. The training and technical skills of the New Zealand School Nurse and the dental auxiliaries of the United Kingdom are not University trained. These three attempts to increase the volume of dental services through the use of skilled auxiliaries show that such personnel can be selected and trained to undertake, under direction, a number of procedures performed by the dentist.

- p. 570 The policy of the Canadian Dental Association, "Auxiliaries should be trained to render a far broader scope of duties than currently feasible, but they should perform these duties under the direct supervision of a dentist, the only person who can assume responsibility for the patient's complete dental care." (C.D.A. Brief to the Royal Commission - page 32.)

We believe that children should be the first beneficiaries of an expansion in dental service. Hence, the approach to the dental health of children must be essentially preventive. This becomes particularly evident when one considers the importance to dental health in adult life of preventive measures in childhood. On the treatment side, dentists have found it difficult to establish priorities.

The shortage of dentists and the acuteness of the problem of dental disorders in children, demands the training of a sufficiently large number of technical competent personnel in a reasonably short period of time, to provide most of the dental services required by children. The evidence presented above concerning the training of auxiliary workers to provide many of the dental services required by children suggests that a similar arrangement could be introduced in Canada. The course of training for the new dental auxiliaries could be patterned on that of dental auxiliaries in the United Kingdom. The training might have to be altered in content, though not lengthened, and facilities to provide training and a work base would have to be established. Clearly final responsibility and authority for all forms of treatment undertaken by the auxiliaries must remain with the dentist.

- p. 571 A program of dental treatment for children ideally should begin with initial care for teeth at the age of three. However, in examining the magnitude of the problem we have concluded that initially the program must begin with the child at the age of 5 and 6.

In the two succeeding years, two additional age groups could be given initial care, while those already in the program are given maintenance care. Example, in the second year of the program, children aged 4 and 5 would be included, while the children treated in the first year, now ages 6 and 7, are given maintenance care. In the third year, the three year olds are added and the 8 year olds are given maintenance care. In each of the following years, one additional age group is brought in, so that by 1980 the children age 3 to 18 will be receiving treatment, assuming, of course, the necessary staff has been assembled to treat them.

C.D.A. estimates on the average time required to give initial care to a child is as follows: -

1. Polishing of teeth, followed by application of
topical stannous flouride - 30 minutes..... 30 minutes

- | | |
|--|----------------------|
| 2. Caries control consultation - 6 minutes..... | 6 minutes |
| 3. Examination for dental caries - 20 minutes..... | 20 minutes |
| 4. Treatment of an average 3.4 cavities per child,
(34 x 52 minutes) - 176.8 minutes, a total of... | <u>176.8 minutes</u> |
| 3.88 hours..... | <u>3.8 hours</u> |

- p. 573 The time required for maintenance care for children already in the programme is estimated at 2.9 hours per child per year. (1,500 hours, the chairside hours of a dentist per year.)

Since much of this work (children) can be done by trained dental auxiliaries under the supervision of a qualified dentist, a ratio of four auxiliaries to one dentist is believed to be the optimum.

We believe that 1,000 auxiliaries could be graduated annually during the first four years and 1,500 thereafter.

In the early years of the programme, it will not be possible to achieve a ratio of four auxiliaries to one dentist, but as the supply of auxiliaries builds up, this ratio can be reached and thereafter maintained. . . . Should this produce more auxiliaries than the programme requires, such auxiliaries should be licensed to work with dentists in private practice.

- p. 574 The Commission assumes that dental schools could supervise the training of between 100 and 150 auxiliaries, either on the school site or in technical institutes. The 1968 target would be 176 auxiliaries for the three prairie provinces. Table 13 and 25, page 574, indicate that a distribution of dental auxiliaries graduated each year would be 49 to Manitoba, 51 Saskatchewan and 77 to Alberta.

- p. 575 Dental Care Needs and Fluoridation

Efficacy of fluoridated water supply in the reduction of dental decay has been fully established.

We are not suggesting that the introduction of fluoridated water would lessen the need for dental services, but that there would be a change in the nature of dental needs.

REPORT OF THE AUXILIARY SERVICES COMMITTEE*

March, 1966

A. EXTENSION OF DUTIES

1. Experimental Studies are being carried out in schools of dental hygiene at the Universities of Alberta, Manitoba and Toronto to deter-

mine the feasibility of preparing the hygienist for increased responsibilities.

Alberta:

- a. polishing of restorations
- b. root planing and curretage
- c. impressions

Manitoba:

- a. taking of impressions of the mouth from which artificial dentures can be made
- b. determining and recording the relationship of one jaw to another

Toronto:

Conducted a study from 1962-64 to determine the capabilities of Dental Hygiene students to undertake expanded duties. They found that 2/3 of the Dental Hygiene students registered during this period of time were capable of performing a wide range of technical procedures.

Dalhousie:

Although not engaged in experimental studies their teaching program has expanded to include:

- a. taking of impressions for study models
- b. polishing of amalgam restorations.

2. Expanded Duties for dental hygienists recommended in Nova Scotia and Ontario in 1965.

Nova Scotia

- a. taking of impressions for study models
- b. selecting and fitting bands and temporary crowns
- c. application of rubber dam
- d. polishing of restorations

Ontario

1. Orthodontic diagnostic record assembly to consist of the following points:
 - a. Profile and full face black and white anthropometric photographs
 - b. Frontal and right and left lateral intra-oral photographs in colour
 - c. Height and weight records obtained by anthropometric standards and plotted on appropriate graphic record
 - d. Cephalometric radiographic survey
 - e. Intra-oral radiographic survey
 - f. Carpal radiograph where required
 - g. Orthodontic study model, poured and trimmed to anthropometric standards
 - h. The measuring and recording of cranial facial characteristics on a cephalometric radiograph after the placement of landmarks by the dental practitioner.

2. Replacement of separation elastics.
3. Preparatory selection of seamless band sizes on models preparatory to band fitting and replacement by the dental practitioner.
4. Beginning of instruction and demonstration in oral hygiene, mouth care and removable appliance placement.
5. Diet analysis for orthodontic patients.
6. Case record assembly at the completion of orthodontic treatment.

The Board also approved the polishing of fillings by a dental hygienist. This procedure was defined as "including the use of disks, stones, finishing burs, and abrasives to finish and polish new and old fillings, but excluding carving contours, margins, occlusal anatomy, interproximal surfaces on the newly inserted filling, and the correction for high spots on both new and old fillings."

* Transactions of the Canadian Dental Association Annual Meeting, Board of Governors, Halifax, June, 1966.

B. C. D. H. A. POST GRADUATE COURSES

Three interesting post-graduate courses have been given and attended by several members of the B. C. D. H. A. Two were presented at the University of Washington, in Seattle, the other in Portland at the University of Oregon Dental School.

University of Washington courses December 1st - 3rd. This course was designed to update methods, facts and visual aids for presenting dental health education to the patient and the community. Participants were urged to bring their own flannel boards, flip charts, overlays, etc. to exchange ideas with others, to revitalize their visuals, or just to start from "scratch" with a new approach. Necessary materials were on hand to do posters, mobiles, lettering, newspaper vegetables-fruit. Most of the second afternoon and the following day were spent actually participating by making visual aids. It was from this course, that several members came back enthused to do something for dental health week, February 5 - 11th. With the cooperation of the B. C. Dental Association, plans were made. Twenty one news items appeared in the papers throughout the province. A dentist and hygienist appeared on T. V., Radio coverage given. The Lieutenant-Governor, Mr. G. Pearkes declared it Dental Health Week in B. C. as did the Mayor of Victoria. The Dental Association has asked that we continue with future dental health education weeks. We also had some good recruitment coverage, as the two Vancouver papers gave us space and pictures on dental hygiene as a career.

April 3rd. This was a short lecture-slide review of White Lesions of the Oral Cavity. Through the use of slides, review was given on leukoplakia, moniliasis, lichen planus, chemical burns, carcinomas and hyperkeratosis. Stress was made that though hygienists are unable to diagnosis the type of lesion, they should be aware of them and the necessity for a thorough examination of the whole oral cavity, tongue and lips, and that any change from the normal should be noted and brought to the attention of the dental practitioner.

The University of Oregon Dental School offered a two day post graduate course for Dental Hygienists September 12, 13th. It was taught by Dr. Walter B. Hall of the Periodontology Dept. and Dr. William Wescott of the Pathology Dept. of the U. of O. D. S.

Dr. Hall's lectures emphasized the importance of home care and discussed the various methods and materials on the market. Various types of Toothbrushes; flosses, unwaxed and waxed; disclosing tablets, the pros and cons of various electric Toothbrushes and water spray devices.

In the afternoon, Dr. Wescott discussed oral pathology and through slides, films and lectures, he stressed the importance of recognizing certain lesions and oddities of the oral cavity, which can be of uppermost importance to the patients well being. Some topics covered included syphilis, vitamin defeciencies, gingivitis (Pregnancy, puberty, dilantin) allergies.

The following morning, Dr. Wescott again lectured to us. Rheumatic fever and bacterial endocarditis were stressed and how as a dental hygienist, we should question patients regarding their medical history and the necessity of charting it. He also discussed oral cancers, supplimenting his lecture with a film on Oral Cancer Examinations.

Dr. Hall finished up the two day session with the current theories on calculus formation, both supra and subgingival, the hardness of calculus and tooth structures and the mode of attachment of calculus to the tooth surfaces. He continued with a discussion of root planning, use of scalers, curretts and the Cavitron.

On a patient in the clinic, he demonstrated the use of curretts and the cavitron. The hand scaling versus ultrasonic vibrations, with advantages and disadvantages of both.

Those of us attending the courses were greatly stimulated, feeling it was well worth the time spent. The topics covered were clear, concise and well illustrated.

POST GRADUATE RADIOGRAPHY COURSE AT ANN ARBOR

The three-day post graduate course in radiography for Dental Hygienists was offered in February of 1967 at the W. K. Kellogg Foundation Institute for Graduate and Post Graduate Dentistry, Ann Arbor, Michigan, U.S.A. This course is given annually by a reknown expert in the field of radiography, Professor A. G. Richards.

The lectures consisted of the following topics:
(These may vary slightly from year to year)

1. Principles of image formation
2. Radiation sources and protection
3. Radiation effects
4. Analysis of technical faults
 - in handling radiographs before, during and after both exposure and processing.
5. Occlusal, extra oral and child techniques
6. Special techniques

Demonstrations

1. Posterior bite-wing technique
2. Long cone periapical technique

Laboratories and Clinics

1. Processing procedures
 - new developments in this field
 - comparative experiments with radiographs of
 - different time exposures
 - different KVP exposures
 - long and short cone exposures
 - types of film
 - different developing times
 - reducing and intensifying techniques
2. Radiation Measurement
3. Long cone periapical technique
4. Occlusal, extra oral and child radiographs

Professor A. G. Richards, during the three days brought us up to date in the field of dental radiography as well as teaching us new and easier techniques and principles.

Those of us who were privileged to take this course (limited to 6 each year) came home eager to practise all that we have learned and with a deep respect for Professor Richards, not only an expert in radiography, but a talented teacher as well.

This would be a most rewarding and informative course for any dental hygienist eager to improve her knowledge and technique in dental radiography.

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION

ANNUAL REPORTS

MAY 1967

President's Report

It has been my privilege and honour to serve as President of the Canadian Dental Hygienists' Association during the past year. When you elected me just a year ago it hardly seemed possible that a year could pass so quickly. I recall my feelings then - pride in the appointment, determination to do well, and nervousness about my ability to fill the position. A full year has passed and owing almost entirely to the unfailing support of the officers, especially Debbie Lang, Secretary, and Carol Ono, Treasurer, through whose efforts much was accomplished, the Committee Chairmen, The Board of Directors, and the members, we have progressed well. I am grateful for this opportunity to express my deepest appreciation for your support, not only for me but for our national association's objectives.

Last autumn each committee chairman was informed of her duties as outlined in the constitution and as recommended by the 1966 Annual Session. The chairmen were asked to communicate frequently with their committee members and to keep the Executive informed of their progress.

Requests were received from the members on the establishing of Insurance Plans, a Placement Service, and on the lowering of Canadian Association fees. In October we corresponded with the Canadian Dental Association and with the supervisor of the CDA Insurance Plans. We can participate in the CDA Group Life and Retirement Savings plans and are advised to use the provincial schemes for medical insurance. For Disability Income protection a new policy would have to be written for hygienists or we could use the C. D. N. A. A. plan. Since then the Ontario Dental Service Plans Inc. has presented a reasonable program for hygienists. The point has been raised that an employer dentist's Liability Insurance plan may not entirely cover a hygienist's actions. The Continental Casualty Company which operates in many provinces now has a plan for hygienists. Details were forwarded to the constituents. Mr. Staddon, Supervisor, felt that we were too widespread and few in number to facilitate the easy application of a national group plan.

Details were distributed to the constituents on the operation of the Ontario Placement Service.

This year brought a vast increase in membership support and with it a large increase of Association funds. This will enable us to do more for the profession - not just the individual. We can look forward to offering scholarships, affording a secretarial service for typing and mailing, to buying and distributing educational materials such as movies and pamphlets for the public, prospective hygiene students, and for the continuing education of the dental hygiene graduate. It can also be used wisely to assist new and small constituent societies to establish themselves.

Constitutions were of prime concern this year. Having worked under constitutions for several years the attendants of the 1966 Annual meeting had constructive criticisms on the efficiency and omissions of certain details. For their benefit each constituent sent in their constitution for scrutiny. The British Columbia constitution underwent further debate on certain points and will be finalized at this Annual meeting. Under the very capable direction of Marg McLean the Canadian constitution was printed in booklet form and an extremely comprehensive and worthwhile Code of Ethics was prepared. Now that the framework of our Associations has been established we will be able to turn our thoughts and time to outward activities.

Unfortunately the chairman of the Special Committee, Hall Report, resigned late in the year and no progress was made by the committee. Both the Manitoba and Ontario Associations however, did extensive research and thinking on the Hall Report and the possible future implications. Their reports will both be presented at this Annual Meeting. The Dental Association has stated that they would prefer to have only the hygienist and to expand her duties. I feel that his subject is of utmost importance and demands our concentrated efforts, now.

Correspondence was received from Dr. Reiger asking us to participate in the Western Canada Dental Convention to be held in Regina, October 1967. The C. D. H. A. was most encouraged to receive this request and details will be handled by Mrs. Betty Holthe of Saskatchewan.

Crest designs were received and sent to the artist for deliberation. A final draft will be presented at this meeting for approval. Pamphlet suggestions, however, have not been submitted.

For the coming years I would like to make the following recommendations.

1) Firstly, I want to emphasize that the real and only purpose of the Canadian Association is to provide national communication and thus encouragement and stimulus for growth, change and improvement. Therefore, I recommend that Journals, Newsletters, and mailings between the provinces, committees, and executive occur frequently.

2) Another problem seems to be the inability to progress rapidly with committee work. I would recommend that besides the representative in each province the chairman be allowed a working committee in her home city.

3) I would recommend that several definite actions be taken to utilize our large bank balance. Perhaps this could include the sub-sidizing of new and small constituents, or to all constituents rather than lowering the fees. It should be used to provide educational material for the public, the graduate hygienist, the hygiene student, and the prospective hygiene student. I believe that the editorial committee, and the entire Executive has a great responsibility to these people.

4) Now that we have dual membership in five Canadian areas let us continue most earnestly to initiate associations in Saskatchewan and Quebec. Although they are small in numbers they are not too small and

will no doubt soon be establishing hygiene schools. I also recommend that we unite the smaller Maritime provinces and Newfoundland, for the time being, into one constituent association, making it possible for those girls other than Nova Scotia to participate actively in the CDHA.

- 5) I recommend that administrative details be minimized leaving time free for more constructive details. At present we can certainly afford to employ a secretarial service for typing and mailings.
- 6) That a resume of the Manitoba and Ontario findings on the Hall Report be distributed to all Canadian members.

In closing, I would ask you to give your new Executive your loyal support and encouragement as you did for me. In a national institution the Executive cannot hope to foresee the problems and wishes of each constituent association, therefore, be encouraged to offer your ideas and support before it is necessary to ask for them. Under the direction of your new president, Jo Gardner, you have every chance for a most successful and progressive year.

For the honour you bestowed on me a year ago and for the ways you helped me to discharge my responsibilities, I sincerely thank you.

This report is respectfully submitted, May 14th, 1967.

Bonnie Snowden, President.

TREASURER'S REPORT

Statement of Receipts and Disbursements
for the period from January 1, 1967 to April 30, 1967

RECEIPTS

Fees received for 1967

219 active members	2,628.00	
55 junior members	110.00	
5 associate members	40.00	
	<u>2,778.00</u>	\$2,778.00
Cash on hand deposited		4.00
Bank interest on savings account		<u>30.00</u>
Total Receipts		\$2,812.00

DISBURSEMENTS

Secretarial Expenses	
(printing, postage and telegram)	29.35
Treasurer's Expenses	
(Postage and stationery)	20.18
Membership Committee Expenses	
(Postage and CDA directory)	22.93
Bank Charges	<u>2.40</u>
Total Disbursements	<u>74.86</u>
Excess of receipts over disbursements	\$2,737.14
Balance of funds December 31, 1966	<u>\$2,102.50</u>
Balance of funds April 30, 1967	<u>\$4,839.64</u>

Respectfully submitted,

Carole K. Ono, Treasurer, CDHA

CANADIAN DENTAL HYGIENIST'S ASSOCIATION
MEMBERSHIP 1967

<u>Constituent Association</u>	<u>Active</u>		<u>Junior</u>	
	<u>1966</u>	<u>1967</u>	<u>1966</u>	<u>1967</u>
Alberta	47	44	16	4
British Columbia	14	24		
Manitoba	10	17	28	30
Nova Scotia	17	24	6	8
Ontario	<u>41</u>	<u>111</u>	<u>6</u>	<u>13</u>
Total	130	220	56	55

Associate membership

Saskatchewan	4
U. S. A.	1

Note:

1. Discrepancy in the total active membership (220) and that reported in the Treasurer's Report (219) was due to the fact that one member having paid her fees late in 1966, was accepted by the CDHA as a 1966 member and by the ODHA as a 1967 member. To prevent complications she was in turn accepted as a 1967 CDHA member, although her fee has been included in total for 1966.
2. This years active membership has an increase of 90 members over that of 1966. The increase is largely due to Ontario having passed dual membership, although all other constituent associations have contributed an appreciable increase as well.
3. Junior membership has not changed in any appreciable amount.
4. Saskatchewan was the only non-constituent province with associate members. Perhaps the membership committee for 1967 might look into the possibility of recruiting members from the other provinces as well.

TREASURER'S REPORT
RECOMMENDATIONS

1. That the transfer of funds be done by the incoming treasurer from the bank of her choice, as opposed to the method used in the past, of the past treasurer forwarding a cheque for the balance of the funds. This would be a safer and less expensive way of having funds transferred.
2. That a dual account be opened
 - (a) a savings account for funds which are in excess of the anticipated expenses

- (b) a current account for funds required for expenses when the treasury books are handed over to the incoming treasurer in August, she can estimate the approximate expenses to be incurred until the following year's fees start to come in. Thus funds in excess of estimate costs can be put into a savings account, which would compile interest. The interest earned would help to offset the bank charges incurred through the year. This year we can expect to gain an interest of \$45.00 (\$30.00 to date)
3. That it become the policy of this association to require two co-signers for handling of this associations funds. One being the treasurer and the other either the president or secretary. This has not been a formal policy of the association although it has been done in the past. This would provide both the treasurer and the association some legal protection.
4. That the transfer of the treasury books be done in August immediately following the completion of the Auditor's report. This would enable the treasurer to become acquainted with her post before her term gets well underway.
5. That for the current year the savings account remain in the Toronto Dominion Bank until the 1st of September 1967, or that the savings account be transferred to a Toronto Dominion Bank in Vancouver. This recommendation is made, in order that the association will not lose the interest to be gained at the end of August 1967. The interest is compiled on a 3 months basis, ours being the end of August.

REPORT OF THE CONSTITUTION COMMITTEE, MAY 1967

The constitution of the C. D. H. A. was adopted on June 13, 1966. The Constitution Committee was charged with the responsibility of having the constitution printed. The printing of 500 copies was completed on March 14, 1967 for a cost of \$98.56. Subsequent to the printing, the Committee was asked to mail a copy of the constitution to each of the 250 members of the C. D. H. A. This is in the process of being completed at the time of writing the annual report.

The Constitution Committee was asked to prepare a Code of Ethics for consideration by the Board of Directors at the 1967 Annual Meeting. This has been completed and forwarded to members of the Board of Directors for consideration.

PROVINCIAL CONSTITUTIONS

British Columbia Dental Hygienists' Association

Arising from old business of the Constitution Committee, the Chairman

of the Committee was asked to correspond with the British Columbia Dental Hygienists' Association and convey the suggested changes that would alleviate conflict between the C. D. H. A. Constitution and the B. C. D. H. A. Constitution. The ensuing volume of correspondence is a matter of record in the Constitution Committee file. The B. C. D. H. A. have complied with all recommendations from the C. D. H. A.

Therefore it is recommended that the British Columbia Dental Hygienists' Association Constitution be officially accepted by the Canadian Dental Hygienists' Association. It is further recommended that the British Columbia Dental Hygienists' Association submit to the Constitution Committee an updated copy of the constitution for file purposes.

The Board of Directors charged the Constitution Committee to review the constituent Association constitutions. Constitutions were received from Nova Scotia, Ontario and Alberta. No constitution was received from Manitoba.

Nova Scotia Dental Hygienists' Association

In the By-Laws section 2, Qualifications sub-section A - Active Members, the qualifications for active membership are not resident specific. This is not in direct conflict with the C. D. H. A. Constitution, but could cause mechanical problems in accepting Nova Scotia members as C. D. H. A. members. This assumption is based on the policy statement for active membership in the C. D. H. A. whereby a dental hygienist must be a resident in the Province of the constituent Association through which she is applying for C. D. H. A. membership.

Therefore it is recommended that the N. S. D. H. Association be encouraged to amend their By-Laws

OR

It is recommended that the application for membership in the C. D. H. A. by prospective members of the N. S. D. H. Association be properly scrutinized for possible conflict.

Ontario Dental Hygienists' Association

The copy of the constitution was received on August 20, 1966 with a letter from Mrs. Patricia Johnson stating that the constitution was up for amendment. The proposed amendments would be forwarded to the C. D. H. A. Constitution Committee before adoption by the O. D. H. A. Comment was deferred by the C. D. H. A. Constitution Committee until the amendments were received. At the time of preparing the annual report, the proposed amendments had not been received and no further progress has been made.

Therefore it is recommended that the Constitution Committee encourage the Ontario Association to submit a copy of the amended constitution for review and re-appraisal by the C. D. H. A. Constitution Committee and as a file copy.

Manitoba Dental Hygienists' Association

No copy of the M. D. H. A. constitution was received by the C. D. H. A. Constitution Committee and no copy is on file. It has been drawn to the attention of the Constitution Committee from outside sources that an area of conflict with the C. D. H. A. constitution does exist.

Therefore it is recommended that Manitoba submit a copy of the constitution for review and possible correction if a conflict does exist and also for a file copy.

Alberta Dental Hygienists' Association

A copy of the constitution was submitted on January 12, 1967. No area of conflict existed. The Chairman of the Constitution Committee was informed of pending amendments. These amendments caused no conflict.

Therefore it is recommended that Alberta file an up-dated copy of the constitution with the C. D. H. A. Constitution Committee.

Respectfully submitted,

(Mrs.) Margaret Berry MacLean, Chairman
(Mrs.) Linda J. Hunter
(Mrs.) Alice Nombourquette
(Mrs.) Sharon Critchley

REPORT OF C. D. H. A. CONVENTION COMMITTEE, MAY 1967

On September 18, 1966, I had my first convention committee meeting. The members were delegated the following positions:

Mrs. Jill Dossett	Registration and Treasurer
Mrs. Donna Leslie	Entertainment and Favours
Miss Ailsa Wood	Speakers and Table Clinic

Our tentative budget and programme were drawn up and ideas for speakers, entertainment, etc., were discussed. Our accountant helped me to draw up the final budget so convention would run at cost. This budget was accepted by the C. D. H. A. Executive on November 30, 1966 (copy enclosed). The committee worked at their duties and by November 30th our enclosed programme was completed with all the arrangements confirmed (ie hotel, speakers, entertainment, etc.).

In January 1967 the Convention Bank account was opened with the \$100. C. D. H. A. advance at Guarantee Trust Company. Both Jill Dossett and I are listed as depositors and I have assumed the signing authority.

In February 1967 a letter and brochure (copies enclosed) were mailed to all Canadian Dental Hygienists, Canadian Dental Hygiene Students, the American Dental Hygienist Association, and the British Hygiene Association.

In early March 1967 another letter with a registration form (copies enclosed) and programme were sent to the above groups. Also a luncheon invitation was sent to each 1967 Canadian Graduate inviting her to the C. D. H. A. luncheon honouring them on May 17th.

We are now in the process of finishing up small convention details (flowers, gifts, menus, decorations, and receiving registrations).

I owe a great deal of praise and thanks to my committee. Their eager work and enthusiasm have been a great help to me and thus to the success of your convention.

At the Annual Meeting I would like to suggest the following:

1) the convention chairman receive a set of the preceeding convention's financial statements. I had no past records and had to do all the budgeting and costing myself. I hope my statements will prove to be a considerable help to next year's convention chairman.

2) the convention chairman should receive some convention expenses in the future (ie accommodation) because of the necessity for her to be present to run convention and to handle any new business.

3) from this year's budget may I suggest the following and make an explanation:

a) There should be a greater discount for pre-registration

	<u>Pre</u>	<u>Post</u>
CDHA member	\$15	\$20
Non-member	\$17	\$22
Junior	\$ 8	\$12
Single Day	\$ 5.50	\$ 8

Pre-registering enables us to be more prepared at the time of convention and provides a better estimate of the money available for convention trimmings. Unfortunately the discount was not attractive enough, although it showed definite signs of working, that is, of May 10th, we have 110 registrations (100 pre and 10 post).

b) The Junior membership registration classification should be changed to "Students" because we want to encourage all students to attend convention and hope that they will become members if they are not already.

c) There is no single meal ticket because it was felt that if a person came for lunch she would most likely attend the whole day's programme. The single day rate really includes just the cost of mailing and printing her share of convention material and the luncheon. Also the hotels like to know preferably 24 hours in advance or the first thing in the morning how many place settings to prepare for lunch. By registering in the morning for the day and getting a meal ticket then the hotel has sufficient time to set things up for us nicely without hopefully last minute confusion. Note that in order to attend any convention function she should register with convention and not just buy a meal ticket.

d) The Canadian President's gift should come from the Canadian treasury not the Convention budget. It is given to her on behalf of all C. D. H. A. members not just those attending convention.

e) A note re registration forms that the following be added: "This receipt is for income tax purposes.", and a place to indicate the specific days attending.

I will give the complete convention file with all correspondence to the Canadian President at the end of May 1967 or as soon as all convention business is completed. Until that time I respectfully submit this report.

(signed) Mrs. Margaret Colman
1967 C. D. H. A. Convention Chairman

REPORT OF THE
EDUCATION AND RECRUITMENT COMMITTEE 1966-67

Dear Madame President:

The members of the Education and Recruitment Committee for 1966-67 were:

Mrs. Anne Mitchell,
27 Lawnwood Drive,
Truro, Nova Scotia.

Mrs. Deborah Bissell,
569 Sheppard Avenue West, Apt. 906,
Downsview, Ontario.

Mrs. Shelley Altman,
1784 Mathers Avenue,
Winnipeg, Manitoba.

Mrs. Marlene Gaalaas,
31-G Grandview Crescent,
Camrose, Alberta.

Miss Dorothy Mayers,
569 Shannon Crescent,
North Vancouver, B. C.

The objectives of this committee for 1966-67 were threefold. First we were to consider preparing an outline to be used when speaking to secondary school students at their Career Days. The second consideration was to supplement the pamphlet, "Dental Hygiene - A Career for Women", which seems to be the only literature that the Canadian Dental Association has available to secondary school students.

Thirdly, this committee was to study the possibility of a scholarship for undergraduate students of Dental Hygiene.

As was suggested by Mrs. Jo Gardner, of the British Columbia Dental Hygienists' Association, perhaps a formal outline would not be necessary or desirable. In British Columbia they use as a guideline an excellent pamphlet prepared by the College of Dental Surgeons of B. C., called "The Profession of Dental Hygiene" and to this speakers add their own working experience. This committee regards this approach to be suitable and adequate, provided the speaker makes use of such up to date material as new university calendars and pamphlets as complete as the above mentioned.

We have also investigated the possibility of having a movie film available to aid in recruitment. The B. C. D. H. A. saw the American Dental Hygienists' Association's film, "A Bright Future" and Mrs. Jo Gardner thought it was quite good. Dr. M. Jackson, of the University of Toronto, has another film, "Dental Hygiene as a Career" which she termed helpful in the field of recruitment. However, these films are very expensive to purchase; therefore this committee feels it would be wise to obtain copies on a loan basis from the American Dental Hygienists' Association for assessment and approval before purchase is considered.

The committee definitely feels that the pamphlet published by the C. D. A. titled "Dental Hygiene - A career for Women" should be discontinued and replaced with a more up to date, attractive folder. The material outlined in "The Profession of Dental Hygiene", by the College of Dental Surgeons of B. C. is very complete. Perhaps it will be a helpful guideline in preparing a pamphlet sponsored by this C. D. H. A. It is hoped the 1967-68 Education and Recruitment Committee will continue in this endeavour.

To consider the possibility of a scholarship for undergraduate students of Dental Hygiene, the members of this committee consulted their local schools of Dental Hygiene. Here is a resume of what was thought.

Mrs. Mary G. Sloanaker of Dalhousie University in Halifax suggested the awards be to students entering their Second Year of study, for their overall performance, and that it be monetary in nature. She also suggested the future possibility of a scholarship for dental hygienists who wish to complete their Bachelor's degree on a full time study basis, and the possibility of establishing a low interest loan programme.

Kate MacDonald, also of Dalhousie University, thinks the award should be based on need rather than strict academic proficiency, but consider a good academic standing (top third of the class) and more emphasis on clinical skills.

Mr. A. G. Read, Secretary of the Faculty of Dentistry, University of Toronto, advised us that the U. of T. Defines scholarships as monetary awards of one hundred dollars or greater, and prizes as lesser monetary awards, or books, plaques, medals, etc. He was also kind enough to inform us what awards are already in existence. There is a \$100. scholarship based on general proficiency which go to the top ranking students of both First and Second Years. In First Year there is a book award based on general merit, and a new \$100. award is presently being established which will probably be based on selected areas of First Year work. Next year a \$200. admission scholarship will be started. In Second Year there is a \$100. memorial award which requires First Class Honours, high standing in clinical work, and participation in extra-curricular activities.

There has been no report from the Manitoba delegate.

The Alberta D. H. A. felt the award should be honorary, in the form of a plaque, and given upon her graduation so that her general proficiency of both years could be evaluated. They determined that no basic academic standard should be defined, but that evaluation should be left up to the Director of the School of Dental Hygiene.

However, further questioning of Alberta and Nova Scotia did not inform this committee of existing scholarships and prizes now available from their local schools of Dental Hygiene; and this is most pertinent information. This information should be obtained and the advice sought of the Treasurer of the C. D. H. A. concerning the value of the awards before the matter can be further discussed.

This is the Annual Report and the recommendations of the Education and Recruitment Committee of the C. D. H. A. respectfully submitted this 11th day of April, 1967.

Respectfully yours,

Deborah Bissell, Chairman.

REPORT OF THE C. D. H. A.
MEMBERSHIP COMMITTEE - 1967

August 1966: -

- letter to committee members drafted and duplicated. Contained: -
 1. Objectives of Membership Committee
 2. Request for names and addresses of (i) registered dental hygienists and (ii) dental hygiene students attending school in province.

September 1966: -

- above letter mailed to members of the committee.
- efforts to draft a "C. D. H. A. Membership Form" commenced.
- Letter regarding the need and advantages of dual membership was hurriedly written and mailed to Mrs. Pat Johnson in an attempt to be on time for the Fall Meeting of the Ontario Dental Hygienists' Association. (The request for this letter was received by the Membership Committee Chairman in Winnipeg on September 28 from Miss Dixie Scoles).
- letter sent to Miss Bonnie Snowdon requesting that some C. D. H. A. stationary be forwarded for committee use. (No reply received)
- ordered a C. D. A. Directory.

October 1966: -

- "C. D. H. A. Membership Form" completed and sent to Winnipeg for duplication. By doing this the C. D. H. A. only had postal expenses which were considerably less than if duplication had been done here in Vancouver.
- Forms mailed to committee members for distribution in their provinces -- after corresponding with Ontario it was decided not to send them out so Ontario and P. E. I. were not included in this venture.

November - December 1966: -

- C. D. A. Directory - 1966 arrived.
- committee members forwarded up to date lists as requested.
- letters sent to dental associations in provinces where no C. D. H. A. Constituent Association exists -- ie. Saskatchewan, Quebec, Newfoundland, New Brunswick, and Prince Edward Island. Letter requested names and addresses of hygienists registered to practise in respective provinces. Membership forms mailed.
- upon receiving lists from committee members a comparison of the lists submitted and the C. D. A. Directory. From this a final draft of Names and Addresses was forwarded to Miss Dixie Scoles, C. D. H. A. Editor, for duplication and distribution to the Executive.

February-March 1967: -

- the returned membership forms were sorted and results studied. Of the approximately 225 forms sent out 104 were returned. The breakdown of these is as shown: -

Active Membership	64
Associate Membership	3
Junior Membership	29 (all Manitoba students)
Not applying for Membership	3**
No response Re: Membership	5

**Reasons for refusing membership were quite different: -

- (i) Travelling for a year in Europe.
- (ii) Majoring in Education (Master's Degree)
- (iii) "I got nothing out of it" -- part of the reason given by an Alberta Hygienist. A letter was mailed giving the "pros" of joining one's professional organization.

Conclusions and Recommendations: -

Having learned from the "Membership Form" experience it is recommended that this type of form not be employed for general use. It is suitable for use in provinces where no constituent association exists; but if the Treasurer notifies this group then even this use is eliminated. The membership committee could seek out reasons why hygienists have refused to join and perhaps deal with these on an individual basis.

This next point may not be considered a part of the realm of this committee but it is recommended that steps be taken to encourage the formation of a constituent association in the provinces of Saskatchewan and Quebec. There are eleven hygienists in Saskatchewan who may be interested. I believe that Miss Virginia Bax of Kamsack would be both willing and capable of undertaking the challenge of starting a provincial organization.

If the students of Alberta, Ontario and Nova Scotia did not become Junior C. D. H. A. Members, it is recommended that a more extensive campaign be launched on the provincial level to encourage membership in the Junior category.

In closing this report I would just like to add that if my successor finds herself as unimaginative as I seem to have been, she may be well-advised to write to the American Dental Hygienists' Association for some ideas.

Respectfully submitted,

(Mrs.) Linda J. Hunter, Chairman,
CDHA Membership Committee
April 1967.

REPORT OF THE
NOMINATIONS COMMITTEE, APRIL 1, 1967

September		
24th	Letter from C. D. H. A. 's Secretary stating duties of Chairman of Nominations Committee.	
November		
2nd	All committee members contacted by letter, giving as a guide, pertinent C. D. H. A. By-Laws and parliamentary rules pertinent to nominations. A blank slate of executive offices and committee members enclosed. Tentative Jan. 1st deadline.	
November		
30th	Reminder sent of tentative deadline of Jan. 1st. With further reminder note that only C. D. H. A. members can vote on the selection of nominees for their constituent association for the C. D. H. A. Slate.	
January		
3rd	Another reminder sent to committee members that had not sent in their filled slate. To date only one received. Progress report sent to C. D. H. A. President, B. Snowdon.	
5th	Following progress report, found that one Constituent committee member stated she wasn't serving on the committee.	
27th	Letter sent to the delgate of the constituent Association for name of the member of this committee	
28th	Letter of clarification on duties of the Special Committee sent to Nova Scotia member of the committee.	
February		
1st	Progress report of the Committee to C. D. H. A. Executive.	
March		
6th	Had heard from all but 2 constituent Associations. Sent in names received to date to C. D. H. A. Treasurer for verification of their eligibility.	
9th	Further nominees names received and sent to Treasurer for verification of their eligibility.	
10th	Letters to several nominees to see if would accept chairmanship of various committees.	
18th	Further nominees to Treasurer for eligibility.	
21st	Further nominees to Treasurer for eligibility.	
April		
1st	Only one affirmative reply accepting Chairmanship of committees. Further letters sent to those nominated.	

The following is the slate of nominees received for the various offices and committee members for the Canadian Dental Hygienists Association for the term of office 1967-68.

Executive Council:

President-Elect:	Mrs. Darlene Thomas	Alberta
	Mrs. Shelly Altman	Manitoba
Secretary:	Mrs. Geri Fraser	Alberta
	Miss Bonnie Buchanan	British Columbia
	(also nominated by Manitoba)	
Treasurer:	Miss Claudia Senton	Manitoba
	Mrs. Sophie Wardach	Alberta
	Miss Mary Anne Schaan	British Columbia
Convention Chairman:	Miss Carol Kline	British Columbia
	(elected by C. D. H. A. Board of Directors, October 25, 1966).	
	Linda Hunter nominated by Manitoba and serving on committee.	

Board of Directors:

Delegate:	Mrs. Marilyn Mabey	Alberta
	Miss Kate MacDonald	Nova Scotia
	Mrs. Karen Wise	Manitoba
		Ontario
	President-elect	British Columbia
	(L. McKittrick probable, B. C. elections after C. D. H. A. Convention).	

Committees:

Constitution	Mrs. M. Berry-MacLean, Chr.	Alberta
	Mrs. Phyllis Marshall	Nova Scotia
	Miss Ruth Chapelle	Manitoba
	Mrs. Wennie Robbins	Ontario
		British Columbia
Editorial	Mrs. Darlene Thomas	Alberta
	Miss Carolyn Lamster	Ontario
	Miss Patricia Wagner	Nova Scotia
	Miss Pat Doherty	Manitoba
		British Columbia
Membership	Miss Carol Ono	Ontario
	Miss Louise Forcier	Alberta
	Mrs. Evelyn Peglar	Nova Scotia
	Miss Carol Matheson	Manitoba
	Treasurer, B. C. D. H. A.	British Columbia
	(D. Mayers probable, B. C. elections after C. D. H. A. Convention)	

Nominating	Miss Lorna Robbins	Ontario
	Mrs. Linda Risdon	Alberta
	Miss Verna Douglas	Nova Scotia
	Miss Roxanna Beaudro	Manitoba
	President-elect B. C. D. H. A.	British Columbia
Education & Recruitment	Mrs. Peggy Sakti	Ontario
	Miss Anne Mackintosh	Alberta
	Mrs. Anne Mitchell	Nova Scotia
	Mrs. Wendy Wilder	Manitoba
		British Columbia
Special	Mrs. Maureen Smith	Alberta
	Miss Allura Canning	Nova Scotia
	Miss Louise Pollard, Chr.	Manitoba
		Ontario
		British Columbia

Recommendations:

Committee Members: Chairmen of C. D. H. A. Committees should be given a list of committee members from Constituent Associations that were elected at the Annual session. Any change of a constituent member should be sent to the Secretary and/or executive of the C. D. H. A. so that the Committee Chairman could be notified immediately and no loss of valuable time is made in writing to the wrong person. On some committees, this could interfere with completion of the committee's task.

Committee Chairmen and Committee Members should be informed as soon after their election at the Annual Session as possible, preferably no later than August 31st.

Convention Chairman: Because of the necessity of making some convention arrangements as early as possible, it might be more valuable to elect the Convention Chairman two years in advance, eg: a Quebec member for Chairman of the convention committee for the C. D. H. A. 1969 convention to be held in Montreal.

Respectfully submitted,

Jo Gardner, Chairman,
C. D. H. A. Nominating Committee

EDITORIAL COMMITTEE RECOMMENDATIONS

1. Decide publication dates at annual meeting
 - a. Number of issues and deadlines
 - b. Budget item for coming year
2. Discuss format of cover
 - a. Title - The Canadian Dental Hygienist
Date
Volume
Crest when available
 - b. Color - Lavender on white
Turquoise on white
 - c. Paper
 - d. Cost
 - e. Exhibit - Dental Health
Journal of the American Dental Hygienists'
Association
3. Discuss booklet
 - a. Size
 - b. Type of print (justified varitype at \$6.50 per page)
 - c. Cost
4. Advertising
 - a. Business manager
 - b. Potential contributors
 - c. Appeal
5. Appeal by form letters to all news sources by September with
 - a. Suggested topics
 - b. Copy of CDHA Style Manual
 - c. Definite deadlines
6. Mailing List
 - a. Manager with mailing lists to compile from all sources
 - b. Complete up-to-date mailing list of
 - 1) Members
 - 2) Non-members (for some issues)
 - 3) Junior members
 - 4) Junior non-members
7. Contact Constituent Editorial Chairmen before September
8. Write CDHA Style Manual
 - a. Brief statement of style and policy
 - b. To be mailed to most potential contributors

9. News Sources

- a. Constituent associations
 - 1) Newsletter
 - 2) Executive news
 - 3) Schools in area
 - 4) Convention and local programs
 - 5) Postgraduate courses
- b. Schools of Dental Hygiene
 - 1) Post graduate courses
 - 2) Changes in curriculum
 - 3) Changes in personnel
 - 4) Student or staff papers written on timely topics
 - 5) Research (Manitoba)
 - 6) Experimental instruction
 - 7) Interesting projects
 - 8) News
- c. Publications
 - 1) All Canadian Dental Hygiene Publications
 - a) Constituent newsletters
 - b) Executive newsletters
 - c) Student news
 - 2) All Canadian dental publications
 - a) C. D. A. Journal
 - b) Governor's Letter
 - c) Provincial journals ie. Le Journal Dentaire du Quebec, etc.
 - d) Directory of Officials
 - e) Directory of Dentists (and Hygienists)
 - 3) Journal of American Dental Hygienists' Association
 - 4) Dental Health (England)
 - 5) Others
- d. Key people
 - 1) CDA officials
 - 2) School directors
 - 3) Association officials
 - 4) Etc.

Respectfully submitted,

Dixie C. Scoles, Chairman
Editorial Committee 1966

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION
BUDGET MEMORANDUM
FOR THE 1967 - 1968 TERM

The attached budget for the 1967 - 1968 term covers the Association's operations from August 1, 1967 to August 1, 1968 (the dates being approximate).

The following memorandum has been prepared for your use in the consideration of the 1967 - 1968 budget.

Budget Work Sheet.....
 Explanations for 1967-68 Budget Estimates.....
 Comparative Financial Report
 Items for Board Decision

Note: The 1967-1968 budget considerations will be more definite after the committee reports are heard and Board decisions are made at the Annual Meeting.

Respectfully submitted,

Carole K. Ono, Treasurer.

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION
BUDGET FOR 1967 - 1968

ITEM	1966 - 1967 Term			1967 - 1968 Term	
	to date Apr. 30/67	Budgeted	Estimated	Estimated	Approved
1a. President	-----	10.00	10.00	20.00	EXEC
1b. Secretary	29.35	100.00	75.00	100.00	175.00
1c. Treasurer	20.18	20.00	30.00	30.00	
2a. Convention Committee	100.00	100.00	100.00	100.00	100.00
2b. Constitution	109.28	125.00			100.00
2c. Editorial	----	500.00	250.00?	500.00	500.00
2d. Hall Commission	----	10.00	10.00	10.00	25.00
2e. Membership	22.93	30.00	22.93	30.00	30.00
3. Convention Travelling	----	350.00	350.00	275.00 or 335.00	360.00
4. Bank Charges	5.85	10.00	10.00	10.00	10.00
5. Audit	----	25.00	25.00	25.00	25.00
Totals	287.59	1280.00			1331.00

COMPARATIVE FINANCIAL REPORT

	Jan. 1 to Dec. 1/65 Actual	Jan. 1 to Dec. 31/66 Actual	Jan. 1 to Apr. 31/67 Actual	Jan. 1 to Dec. 31/67 Estimate	Jan. 1 to Dec. 31/68 Estimate
RECEIPTS	1965	1966	1966	1967	1968
Current year's fees	1068.00	1628.00	2778.00	2840.00	3080.00
Fees for following year	56.00			60.00	60.00
Convention excess (incl. advance)	54.16	176.35		100.00	100.00
Bank interest			30.00	45.00	60.00
Miscellaneous			4.00	4.00	
TOTAL RECEIPTS	1178.00	1804.35	2812.00	3049.00	3300.00
Disbursements Total	422.87	791.79	74.86	875.00	1210.00
Excess of receipts over disbursements	755.29	1012.56	2737.14	2174.00	2090.00
Balance of Funds	+334.65 =1089.94	2102.50	4839.64	4276.50	6266.50

Note: The estimates for 1967 are just rough figures which I feel will be fairly accurate. Those for 1968 are based on the following:

- receipts - 20 active members added to the 1967 estimate
- disbursements - from the budget estimate for 1967-68 using the figures of 50.00 for the constitution committee and the high estimate for convention travelling expenses. \$335.00

This comparative financial report was prepared to show the Board of Directors and the Executive the financial increases made by this Association in the past few years.

Explanations for the 1967 - 1968 Budget Estimates

1. Executive Expenses

a. President - \$20.00

The previously allotted amount of \$10.00 does not cover a great deal and it is suggested that the amount be raised to

\$20.00 to cover the expenses of postage, duplicating and general correspondence.

b. Secretary - \$100.00

Although this year's secretarial expenses to April 20, 1967 was \$29.35 and the estimate at the term's end is only expected to be about \$75.00, it is advised to keep the budget for operating costs at \$100.00, since the expenses to be incurred greatly depend upon the typing and duplicating services employed by the executive.

The typing this year was done by the executive and the duplicating services were provided by the CDA at cost (\$.05 per sheet).

c. Treasurer - \$30.00

The budget is estimated on the following expenses:

- envelopes (small)	300 x .01 =	3.00
- envelopes (large)	50 x .05 =	2.50
- postage		16.50
- membership cards		5.00
- shipping treasury books		3.00
Total		<u>\$30.00</u>

Since much of the operating costs of the President, Secretary and Treasurer are co-ordinated a suggestion that the budget allotted, be in the form of a lump sum for the entire executive, is being made. This would permit an executive member to exceed her budget to a slight degree without formally requesting an approval from the Board of Directors.

2. Committees Expenses

a. Convention Committee - \$100.00

The previous year's (1967) advance to the Convention Committee of \$100.00 for expenses incurred prior to the receipt of convention fees was sufficient and it is anticipated that it will be for the 1968 Convention.

b. Constitution Committee -

The amount required is subject to the Constitution Committee's Chairman's report to be presented at the annual meeting. However the expenses of this committee is expected to be less in the following year.

c. Editorial - \$500.00

It was anticipated that 2 journals would have been printed this year but due to unforeseen circumstances, none has been printed to date. However the budget should remain for 1967-68 as approved for 1966-67, in anticipation that at least two journals will be printed.

d. Hall Commission - \$10.00

e. Membership - \$30.00

3. Convention Travelling and Accommodation Expenses - \$275.00
or \$335.00

Accommodation:

It is recommended that accommodation for the following people be permitted, during convention:

President, President-elect, Secretary, and Treasurer - their presence is required for board meetings which I understand, may be called after regular convention time if needed to finish association business.

Convention Chairman - her presence is required at all times, to oversee the smooth operation of the convention.

Therefore 4 nights, at \$10. each for 5 persons
 $5 \times 4 \times \$10. = \$200.$

Travelling:

This is dependent on the outcome of the ballot for President-Elect.

- | | | | |
|----|--------------------------------|----------|---------------|
| a. | cost - Edmonton to Vancouver.. | \$66.00 | Plus |
| | with leeway | \$75.00 | Accommodation |
| b. | cost - Winnipeg to Vancouver. | \$126.00 | \$275.00 OR |
| | with leeway..... | \$135.00 | \$335.00 |

4. Bank Charges - \$10.00

5. Audit - \$25.00

Items for Board Decision

1. Mr. Jack Dossett, the original auditor for this association was approached to handle our account for 1966-67. He has consented to do so for the budgeted amount of \$25.00. To date the books have been audited once (Dec. 31/66) and will be again at the end of term of office. A formal Board decision is required on the approval of the auditor.

2. A request for an additional \$10.00 for treasury expenses, to cover costs for new membership cards and shipping costs. The allotted amount has been spent to date on envelopes, postage and telegrams.

REPORT OF THE
C. D. H. A. SPECIAL COMMITTEE

I should explain that I have not been the acting chairman of this committee. I have been a committee member only, acting as Manitoba's representative to the committee. Mrs. Bernice Brown, the appointed chairman was unable to serve in this capacity this past year because of heavy family responsibilities. My report, therefore, is an outline of the work carried out by the Manitoba Dental Hygienists' Association and not the Canadian Dental Hygienists' Association. A directive to this committee from the C. D. H. A. Executive requested that an up-to-date statement be compiled on the views of Canadian hygienists regarding the Hall Commission Report.

In October, 1966 the M.D.H.A. made three suggestions concerning the work of the Special Committee.

1. That certain sections of the Hall Commission which "may" directly affect the future of the profession of dental hygiene, be published either in the C. D. H. A. Journal or in a separate publication. This suggestion was made since part of the problem of this committee in trying to arrive at an up-to-date statement of the C. D. H. A. 's views on the Hall Commission has been a lack of familiarity by most hygienists on its contents. Such a publication was not an original idea as both Nova Scotia and Alberta had published such excerpts.
2. That a very definitive statement of the Canadian Dental Hygienists' Association's views and recommendations be sent to the Canadian Dental Association's representative on the Hall Commission. Various representatives of the different health fields sent representatives to a conference held in Ottawa in the fall of 1965. If future meetings are to be held the C. D. H. A. should consider the possibility of sending a representative of their own to such a meeting. If we are continually "represented" by the C. D. A. in such matters we will never become our own spokesman.
3. That perhaps the goals of this committee be extended.

In an attempt to arrive at an up-to-date statement of the Hall Commission, the M. D. H. A. held a Study Club with the idea of studying and discussing more closely the implications of the Hall Report. Prior to the Study Club meeting, copies of sections of the Hall Commission were distributed to each M. D. H. A. member along with a list of the expanded duties being carried out in the four schools of dental hygiene as outlined in the 1966 C. D. A. Transactions.

Although this was only a beginning, this Study Club did help our Association become more aware of the possible changes in the future role of the hygienist and the powers who are likely to bring about this change.

In conclusion, I would make the following recommendations to the C. D. H. A. Executive and Board of Directors as to the future work of this Committee:

1. That if the C. D. H. A. wants an up-to-date statement of its members' views on the Hall Commission then I think every C. D. H. A. member should be a) informed and b) asked to give her opinion and comments. This, I think, could be done in the form of a) summary on the Hall Commission and b) a brief questionnaire to each member carried out by the provincial associations under the direction of Special Committee's Chairman. I suggest that sufficient funds be set aside for the purpose.

2. That , if possible, the C. D. H. A. have separate representation to the conference on the Hall Commission.

3. That the goals be broadened.

Respectfully submitted,

Louise E. Pollard,
M. D. H. A. Special Committee

May 12, 1967
Winnipeg, Manitoba

REPORT OF THE TABLE CLINIC

given by the CDHA at the CDA-ODA Centennial Convention - May 1967.

Madame President, fellow Hygienists:

The Canadian Dental Hygienists' Association represented by Miss Ailsa Wood and Miss Pat Johnson presented a Table Clinic at the CDA-ODA Convention on Monday, May 15th, 1967.

The Clinic was entitled "Why Use Displacement Pack?".

Using Displacement Pack to advantage in edematous gingival pockets of less than 5 mm. was noted but the using of it was demonstrated on case models. The ingredients of this pack and the mixing of them were shown through various stages.

Advantages of using displacement pack and tips in its use were illustrated in posters. Pamphlets also were made available for those wishing a copy of this information.

Since Displacement Packing is taught only in Ontario, it is our hope that we have interested more dentists and dental hygienists in its use.

Respectfully submitted,

Miss Pat Johnson

Dated at Toronto the 16th May

MINUTES OF THE FOURTH ANNUAL BOARD SESSION OF THE
CANADIAN DENTAL HYGIENISTS' ASSOCIATION.

The Board of Directors of the Canadian Dental Hygienists' Association met on Sunday, May 14, 1967, at the Royal York Hotel in Toronto, Ontario. All members of the Executive Council were present. Miss Dixie Scoles - Past President, Miss Bonnie Snowdon - President, Mrs. Jo Gardner - President-Elect, Mrs. Debbie Lang - Secretary and Miss Carole Ono - Treasurer. The five delegates to the Board of Directors were present. Mrs. R. Silko from Alberta, Mrs. K. Wise from Manitoba, Miss Kate MacDonald from Nova Scotia, Mrs. Pat Johnson from Ontario, and Miss Ruth Carter from British Columbia. Also attending were Mrs. Marg MacLean, Chairman of the Constitution Committee and Miss Louise Pollard representing the Special Committee and Mrs. Marg Colman, Chairman of the Convention Committee. Bonnie Snowdon was acting chairman and Debbie Lang was recording secretary. Also present was Mrs. S. Altman.

Bonnie suggested that the Annual Reports not be read and that discussions be limited to the recommendations of the reports.

1. REPORT OF THE PRESIDENT previously submitted to the Board by Bonnie Snowdon.

MOTION.... by Pat Johnson... that the President's Report be adopted as written seconded by Karen Wise.... CARRIED

Recommendation 1 -

MOTION.... by Pat Johnson... that Journals, Newsletter, and mailings between the provinces, committees, and executive occur frequently seconded by Shelly Altman..... CARRIED

Recommendation 2 -

MOTION... by Jo Gardner that the chairman of each committee be allowed a working committee in her home city but that all decisions remain on the Canadian level..... seconded by R. Sitko.. CARRIED

Recommendation ... by Shelly Altman to provincial constituents that representatives to Canadian committees be represented, perhaps as chairman, on the provincial level in that committee.

Recommendation 3 - re utilizing our large bank balance

MOTION... by Carole Ono.... that the CDHA offer as much assistance as possible to new constituent associations by forwarding an outline of the necessities of establishing a provincial association and a constitution and in time work this out as to cost and submit a report to the Board of Directors..... seconded by Kate MacDonald..... CARRIED

MOTION....by Karen Wise....that the CDHA subsidize local constituent with regard to travelling expenses to the CDHA Board meetings upon receipt of a financial report on the association's standing and this is to be sent to and approved by the Board of Directors.....seconded by Pat Johnson..... CARRIED.

MOTION...by Pat Johnson....that the CDHA be forewarned of all meetings involving the interests of dental hygienists and that the President be charged with delegating a person to attend that meeting and also be charged with the responsibility of deciding funds for that person to attend (this amount to be approved by the Board).

Recommendation 4 -

MOTION....by Kate MacDonald....that the CDHA contact Mrs. Betty Holthe of Saskatchewan sending her details of organization of a provincial association, an outline of a constitution and a statement regarding the CDHA's feelings on financial aid and that the CDHA keep in mind the possibility of setting up constituent associations in Quebec and the Maritime provincesseconded by Carole Ono

Suggestion...by Jo Gardner....that a "pre-organization meeting" be held during the October convention in Regina with representatives from Manitoba, Alberta and B.C. to help the hygienists in Saskatchewan.

Recommendation 5 -

MOTION...by Jo Gardner....that secretarial services be utilized where necessary for typing, copying and mailing....seconded by Pat Johnson..... CARRIED

MOTION. by Kate MacDonald....that a letter be written to the registrars in all provinces where there is no register for hygienists to emphasize that all hygienists must be registered.

Recommendation 6 - re Hall Report -

MOTION - by Jo Gardner....that a report and statement of policy should be sent to all hygienists to make them realize the importance of this issue...seconded by Pat Johnson (see Special Commission for further discussion).

2. REPORT OF THE TREASURER previously submitted to the Board by Carole Ono.

MOTION....by Pat Johnson.....that the Treasurer's Report be adopted as written.

Recommendation 1 - re transfer of funds.

MOTION by Bonnie Snowdon . . . that recommendation 1 be adopted as written . . . seconded by Jo Gardner . . . CARRIED

Recommendation 2 - re dual account -

MOTION by Bonnie Snowdon . . . that recommendation 2 be adopted as written seconded by Karen Wise CARRIED

Recommendation 3 - re two co-signers -

MOTION by Bonnie Snowdon . . . that recommendation 3 be adopted as written seconded by R. Sitko CARRIED

Recommendation 4 - re transfer of book -

MOTION by Bonnie Snowdon . . . that recommendation 4 be adopted as written seconded by Pat Johnson . . . CARRIED

Recommendation 5 - re saving account -

MOTION by Bonnie Snowdon . . . that recommendation 5 be adopted as written seconded by Kate MacDonald . . . CARRIED

3. REPORT OF THE CONSTITUTION COMMITTEE previously submitted to the Board by Marg MacLean.

MOTION by Pat Johnson . . . that the report of the Constitution Committee be adopted as written seconded by Carole Ono CARRIED

Recommendation 1 - re British Columbia D. H. A. Constitution -

MOTION by R. Sitko . . . that recommendation 1 be adopted as written seconded by Pat Johnson CARRIED

Recommendation 2 - re Nova Scotia D. H. A. Constitution -

MOTION by Bonnie Snowdon . . . that the second part of recommendation 2 be adopted as written seconded by Ruth Carter CARRIED

POLICY MOTION . . . by Bonnie Snowdon . . . that all hygienists applying for membership in the CDHA complete an application for membership which would include their residency seconded by Carole Ono CARRIED

Recommendation 3 - re Ontario D. H. A. Constitution -

Marg MacLean stated that the Constitution from Ontario had been

received since she submitted her report and that she had sent her personal comments to the ODHA but that there had not been sufficient time to contact her committee.

MOTION....by Bonnie Snowdon....that there be further consideration of the ODHA Constitution during the summer months.....
seconded by Ruth Carter..... CARRIED

Recommendation 4 - re Manitoba D. H. A. Constitution -

Marg MacLean stated that the Constitution from Manitoba had been received and that one matter required consideration regarding residency.

MOTION.... by Bonnie Snowdon....that the Manitoba D. H. A. further consider their constitution during the coming year with regard to "Active member who is registered" to "Active member who is residing in the province through which she is applying"....
seconded by Carole Ono.... CARRIED

Recommendation 5 - re Alberta D. H. A. Constitution -

MOTION.....by Bonnie Snowdon.....that Alberta file an updated copy of the constitution with the CDHA Constitution Committee.

CODE OF ETHICS

MOTIONby Bonnie Snowdon.....that the Code of Ethics be adopted as read with the change in the section entitled "Obligations to the Patient and the Public" section c from the phrase "associate dentist" to "dentist with whom she is associated"..... seconded by Jo Gardner... CARRIED

4. REPORT OF THE CONVENTION COMMITTEE previously submitted to the Board by Marg Colman

MOTIONby Bonnie Snowdon....that the report of the Convention Committee be adopted as written.... CARRIED

Recommendation 1 - records of convention committee -

MOTION..... by Bonnie Snowdon....that recommendation 1 be adopted as written and that the retiring chairman of the Convention Committee pass on to next year's chairman all past records, recommendations, and schedules..... seconded by Carole Ono
.... CARRIED

Recommendation 2 -

MOTION....by Bonnie Snowdon....that the Convention Chairman be in charge of the Hospitality Room which would be her room at night

as well as the room for the Annual Session and that she receive funds for the convention which would include the costs of the Hospitality Suite. . . . seconded by Carole Ono. . . . CARRIED

Recommendation 3a - re greater discount for pre-registration -

MOTION. . . . by Bonnie Snowdon. . . . that recommendation 3 be adopted as written, seconded by Pat Johnson. . . . CARRIED

Recommendation 3b - re Junior Membership registration -

MOTION. . . by Bonnie Snowdon. . . . that recommendation 3b be adopted as written. . . . seconded by Karen Wise. . . . CARRIED

Recommendation 3c - re single meal ticket -

MOTION by Bonnie Snowdon. . . . that recommendation 3c be adopted as written, seconded by Carole Ono. . . . CARRIED

Recommendation 3d - re Canadian President's gift -

MOTION by Bonnie Snowdon. . . . that recommendation 3d be adopted as written. . . . seconded by Pat Johnson. . . . CARRIED

MOTION. . . by Carole Ono. . . . that we institute a symbol for the President such as a President's Pin, Chain of Office or Gavel to make the office of President significant at Dental Functions seconded by Karen Wise. . . . CARRIED

Recommendation 3e -

MOTION by Bonnie Snowdon. . . . that recommendation 3e be adopted as written. . . . seconded by Pat Johnson. . . . CARRIED

5. REPORT OF THE SPECIAL COMMITTEE submitted by Louise Pollard and read by Bonnie Snowdon

MOTION. . . by Bonnie Snowdon. . . . that the Report of the Special Committee be adopted as read. . . . seconded by R. Sitko. . . . CARRIED

Recommendation 1 - re questionnaire -

MOTION by Bonnie Snowdon. . . . that recommendation 1 be adopted as read with a budget of \$25. being set aside for the purpose. . . . seconded by Carole Ono. . . . CARRIED

Recommendation 2 - re separate representation to conference on state commission -

MOTION by Bonnie Snowdon. . . . that the Special Committee be renamed to include the future opportunities, education and

duties of the hygienist and henceforth be called the Special Committee for Dental Auxiliary Services..... seconded by Kate MacDonald.... CARRIED

MOTION.....by Louise Pollard... that a sub-committee of the Special Committee be set up to work in conjunction with the Education and Recruitment Committee to deal with the matter of complete utilization of the hygienist by the dentist and to promote this concept by the use of movies, film strips and better communication with them..... seconded by Pat Johnson.... CARRIED

Suggestions.... by Pat Johnson.... 1. that the CDHA confer with the CDA for representation on their committees dealing with hygienists and auxiliary personnel and ask that we be included in and receive reports from these committees.

2. that the CDHA prepare a statement of policy to be presented to the C. D. A. Auxiliary Services Commission expressing our dissatisfaction with our present duties, our desire to expand our duties and our concern over the dental attitude, provincially and nationally, toward the utilization of hygienists.

3. by Jo Gardner... that the slides and taped talk shown at the Mid winter Clinic in B. C. could be useful to the new sub-committee.

4. by Pat Johnson... that the CDHA prepare a convention presentation for dentists to demonstrate how dentists may completely utilize hygienists.

Recommendation 3 - re broadening of goals -

MOTION by Bonnie Snowdon... that recommendation 3 be adopted as read..... seconded by Pat Johnson..... CARRIED

6. REPORT OF THE EDUCATION AND RECRUITMENT COMMITTEE previously submitted to the Board by Deborah Bissell

MOTION by Bonnie Snowdon... that the report of the Education and Recruitment Committee be adopted as read..... seconded by Pat Johnson..... CARRIED

Shelly Altman gave a brief report on the two types of scholarships offered in Manitoba. Kate MacDonald stated that two prizes were offered at Dalhousie.

Suggestion..... by Bonnie Snowdon..... that since three new schools of Dental Hygiene will be set up in the future, it would not be financially possible to offer all seven schools substantial scholarships, and that the matter of scholarships be left to the Education and Recruitment Committee.

7. REPORT OF THE MEMBERSHIP COMMITTEE previously submitted to the Board by Linda Hunter

MOTION by Bonnie Snowdon..... that the report of the membership committee be adopted as written.... seconded by Jo Gardner..... CARRIED

Recommendation 1 - re "membership form"

MOTIONby Bonnie Snowdon...that the use of the "membership form" be continued because of the residency problem in different constituents and that the membership chairman send them to the constituent treasurers.

Recommendation 2 - re constituent associations in Saskatchewan and Quebec -

MOTION.....by Bonnie Snowdon that an association in Saskatchewan be encouraged as outlined in recommendation 4 of the President's Report and that the problem of Quebec be looked into in the future by the CDHA Executive.... seconded by Pat Johnson..... CARRIED

Recommendation 3 - re Junior Membership

MOTIONby Bonnie Snowdon...that recommendation 3 be adopted as written.... seconded by Carole Ono.... CARRIED

Suggestions.....1. By Pat Johnson...that a letter from the Canadian President be presented to these girls and the provincial president speak to them personally.
2. By Pat Johnson...to the Editorial Committee that there be an exchange of junior membership ideas such as summer employment in the Journal.
3. by Kate MacDonald...that the Editorial Committee correspond with the students ie class presidents or presidents of the Dental Hygiene society in the schools.
4. By Jo Gardner...that this committee obtain an American Dental Hygiene Kit for its use.

8. REPORT OF THE EDITORIAL COMMITTEE submitted by Dixie Scoles and read by Bonnie Snowdon

MOTIONby Louise Pollard...that the report of the Editorial Committee be adopted as read... seconded by Pat Johnson..... CARRIED

MOTION.....by Bonnie Snowdon...that a newsletter go out in June to all Canadian hygienists..... seconded by Carole Ono.... CARRIED

MOTION...by Bonnie Snowdon...that two Journals be published, one in November and one in April... seconded by Pat Johnson... CARRIED

MOTION.....by Bonnie Snowdon...that discussion of the Budget be deferred until discussion of the Budget Memorandum..... seconded by Carole Ono..... CARRIED

MOTION.....by Bonnie Snowdon...that the title of the Journal be "the Canadian Dental Hygienist"... seconded by Jo Gardner... CARRIED

MOTION....by Bonnie Snowdon....that we make use of commercial advertising..... seconded by Ruth Carter..... CARRIED

MOTION....by Bonnie Snowdon....that the treasurer keep the Editorial Chairman up to date on listings and changes..... seconded by R. Sitko..... CARRIED

MOTION....by Bonnie Snowdon....that there be a constant flow of information between the national and provincial committees.

9. REPORT OF THE NOMINATING COMMITTEE previously submitted by Jo Gardner

MOTION....by R. Sitko...that the report of the Nominating committee be adopted as read..... seconded by Kate MacDonald... CARRIED

Recommendation 1 - re list of committee members -

MOTION....by Bonnie Snowdon.....that recommendation 1 be adopted as written..... seconded by Pat Johnson.... CARRIED

Recommendation 2 - re informing chairmen and committee members -

MOTION....by Bonnie Snowdon....that recommendation 2 be adopted as written and that Jo Gardner take care of this matter..... seconded by Karen Wise..... CARRIED

Recommendation 3 - re election of convention chairman two years in advance -

MOTION.....by Bonnie Snowdon....that recommendation 3 be adopted as written... seconded by Carole Ono..... CARRIED

Karen Wise stated that Mrs. Wendy Wilder and Mrs. Pat Kerr of Manitoba will act as co-chairmen for the 1969 Convention.

10. ELECTION OF MEMBERS OF THE EXECUTIVE COUNCIL

A. PRESIDENT-ELECT

The nominations of Mrs. Darlene Thomas and Mrs. Shelly Altman were approved.

MOTION....by Bonnie Snowdon....that nominations close, seconded by R. Sitko..... CARRIED.

A vote was taken by a show of hands and Mrs. Shelly Altman was elected President-Elect.

B. EXECUTIVE SECRETARY

The nominations of Mrs. G. Fraser and Miss Bonnie Buchanan were approved.

MOTION....by Bonnie Snowdon...that nominations close...seconded
by Kate MacDonald..... CARRIED

A vote was taken by a show of hands and Miss Bonnie Buchanan was
elected Executive Secretary.

C. TREASURER

The nominations of Miss Claudia Senton and Mrs. Sophie Wardach
were approved.

MOTION.....by Bonnie Snowdon....that nominations close...
seconded by Jo Gardner..... CARRIED

A vote was taken by a show of hands and Miss Claudia Senton was
elected Treasurer.

D. CONVENTION CHAIRMAN

Mrs. Carol Kline had been elected by the Board of Directors on
October 25, 1966.

11. APPROVAL OF MEMBERS OF THE BOARD.

The name of Mrs. Pat Johnson was added as the delegate from Ontario.
Kate MacDonald stated that the delegate from Nova Scotia would change
with their elections in June.

The nominations for the Board of Directors were approved. (See List
of Nominations for 1967-68.)

12. APPROVAL OF MEMBERS OF COMMITTEES AND APPOINTMENT OF COMMITTEE CHAIRMEN

A. CONSTITUTION COMMITTEE

The nominations for members of the Constitution Committee were
approved (see List of Nominations for 1967-68. Miss Ruth Chapelle
should be Chappell). Mrs. Marg Berry MacLean was appointed
Chairman.

B. EDITORIAL COMMITTEE

The nomination for members of the Editorial Committee were approved
(see List of Nominations for 1967 - 68) Mrs. Patricia Wagner will
become Mrs. Patricia Hannigan. Miss Pat Doherty will become Mrs.
Pat Kerr. Miss Pat Doherty (Mrs. Pat Kerr) was appointed Chairman.

C. MEMBERSHIP COMMITTEE

The nominations for members of the Membership Committee were
approved (see list of Nomination for 1967-68).. Miss Bonnie Snowdon
was appointed Chairman.

PHOTOCOPY SERVICE

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D. NOMINATING COMMITTEE

The nominations for members of the Nominations Committee were approved (see List of Nominations for 1967-68) Miss Shelly Altman was appointed Chairman.

E. EDUCATION AND RECRUITMENT COMMITTEE

The nominations for members of the Education and Recruitment Committee were approved (see List of Nominations for 1967-68) Mrs. Peggy Bakti was appointed Chairman.

F. SPECIAL COMMITTEE FOR DENTAL AUXILIARY SERVICES

The name of Mrs. Peggy Dolman was added as the member from Ontario. The nominations for the Special Committee were approved (see List of Nominations for 1967-68). Miss Louise Pollard was appointed Chairman.

13. CDHA BUDGET FOR 1967-68 previously submitted by Carole Ono.

MOTION....by Bonnie Snowdon....that the Executive expenses be increased to \$175. to accommodate the need for new stationery
.....APPROVED.

MOTION....by Bonnie Snowdon....that the revolving account of \$100. budgeted for the Convention Committee be approved....APPROVED

MOTION....by Bonnie Snowdon....that the amount of \$100. budgeted for the Constitution Committee be approved. This amount includes an estimated \$75. for the publication of the Code of Ethics in booklet form and \$25. for stationery...APPROVED

MOTION....by Bonnie Snowdon....that the amount of \$500. budgeted for the Editorial Committee be approved....APPROVED.

Carole Ono noted that the 1966-67 Editorial Committee estimates now that it will use about \$125. to \$150. of the \$500. allotted to it.

MOTION....by Bonnie Snowdon....that the amount of \$25. budgeted to the Special Auxiliary Services Committee be approved.....
APPROVED.

MOTION....by Bonnie Snowdon....that the amount of \$30. budgeted to the Membership Committee be approved....APPROVED

MOTION....by Bonnie Snowdon....that the amount of \$360. budgeted to Convention Travelling, including \$150. for accommodation, \$135. for transportation for the President-Elect, and \$75. for travelling for the Vice-President, be approved....APPROVED.

MOTION....by Bonnie Snowdon....that the amount of \$10. budgeted for Bank Charges be approved....APPROVED

MOTION....by Bonnie Snowdon that the amount of \$25. budgeted for Audit expenses be approved.....APPROVED

MOTION.....by Bonnie Snowdon....that the amount of \$100. budgeted for the Education and Recruitment Committee be approved.....APPROVED.

This increase is due to the setting up of the sub-committee of this committee to produce promotion movies, film strips, pamphlets etc., dealing with the complete utilization of the hygienist.

MOTION....by Carole Ono..... that Mr. Jack Dossett be approved as Auditor for this year and Mr. A. P. Gardner be approved as auditor for next year.....APPROVED.

MOTION....by Bonnie Snowdon..... that an additional \$10. be approved for treasury expenses.....APPROVED

MOTION....by Jo Garnder.... that no new membership cards be printed and that the remaining ones be used.....APPROVED

MOTION.....by Bonnie Snowdon..... that the dues for membership remain the same..... seconded by Carole Ono.... CARRIED

MOTION....by Bonnie Snowdon..... that the President and Editor receive the American Dental Hygiene Journal, British Dental Hygiene Journal and the CDA Journal,..... seconded by Carole Ono..... CARRIED

Discussion.... These journals should be kept to be placed in the future in the CDHA national office. The CDA Library will be asked to keep them for us until such time.

14. THE PROPOSED CREST

Three professionally drawn design-sketches were submitted by the executive. These three designs incorporated all ideas submitted to the executive.

MOTION..... by Bonnie Snowdon..... that we have the crest professionally processed by the artist who drew the sketches incorporating these ideas: founded 1963, a small, vague maple leaf superimposed with CDHA, and no colour, and that we allot \$75. for this purpose..... seconded by Pat Johnson..... CARRIED

15. SPECIAL POINTS REGARDING MEMBERSHIP

MOTION..... by Bonnie Snowdon..... that we do not accept the suggestion of instituting inactive membership for ladies who are unwilling to pay full membership fees..... seconded by R. Sitko.... CARRIED

MOTION....by Bonnie Snowdon....that it become a policy of this association that when a member transfers from one constituency to another, she remains an active CDHA member but she must pay the fees for active membership in the new constituency and it is left up to the constituencies to deal with the funds.

MOTION....by Bonnie Snowdon.....that Junior members automatically become active members upon graduation..... seconded by Carole Ono..... CARRIED

16. INSURANCE PLANS

Bonnie Snowdon stated that a Disability Plan is available in Ontario and that copies will be forwarded to the new executive for use by interested provinces. Also liability insurance must be done through the provinces.

17. MEMBERSHIP CHAIRMAN

MOTION....by Bonnie Snowdon....that we continue to have a Membership Chairman..... seconded by Ruth Carter..... CARRIED

18. OTHER BUSINESS

MOTION....by Bonnie Snowdon....that it become a policy of this Association to send a telegram of congratulations to each graduating class of Dental Hygiene and signed "the Board of Directors of the CDHA..... seconded by Kate MacDonald..... CARRIED.

Suggestion....that these be sent by the delegates in the constituents where schools are located.

Suggestion...that the new Chairman of the Education and Recruitment committee obtain copies of the pamphlets available in Manitoba. and contact Ruth Carter for copies of the pamphlets available in B. C. Also that she obtain a supply of Calenders for the Schools of Dental Hygiene and pamphlets to answer requests for information on Dental Hygiene. She should inform the CDA that she is available for this purpose.

MOTION....by Pat Johnson....that a sub-committee of the Special Committee be set up to deal with the idea of Reciprocity between the provinces and to study the accredited universities to see if it would be possible to establish a basic uniform curriculum, thus illiminating the necessity of written exams when changing provinces,.... seconded by R. Sitko.... CARRIED

MOTION....by Bonnie Snowdon....that Pat Johnson be approved as Chairman of this sub-committee.

Discussion.... The reciprocity would be limited to the basic education and certain clinical aspects would be left up to the provinces. Hygienists would be allowed to take postgraduate courses in this clinical aspect. All aspects of reciprocity should be looked into thoroughly and then all recommendations should be sent to the C. D. A.

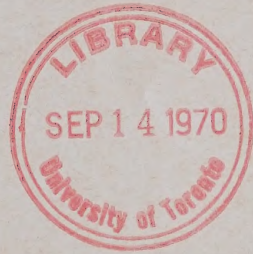
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THE CANADIAN
DENTAL HYGIENIST

FALL
1967



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THE CANADIAN DENTAL HYGIENIST

OFFICIAL PUBLICATION OF
THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION

EDITORIAL COMMITTEE

Mrs. Patricia Kerr, chairman
404 - 625 Broadway Avenue
Winnipeg 1, Manitoba
Miss Carolyn Lanster
Miss Susan Lightall
Mrs. Patricia Hannegan
Mrs. Darlene Thomas

TABLE OF CONTENTS:

	Page
President's Message	3
Editor's Message	4
From the Membership Chairman	5
A Study of Four Disclosing Solutions	6
Number of Dental Hygienists Continue to Increase	10
Your Choice of Topical Fluoride Therapy	11
Senior Dental Hygienist - A New Position	17
Dental Hygiene Practice in Northern Canada	19
Dental Personnel in Canada 1967	21
The Western Canada Dental Hygiene Convention	22
What is in the Future for the Dental Hygienist?	24
The Necessity of a Dental Hygienists' Association	27
C.D.H.A. Convention, 1968	30
Guess What We're Doing	31
Bulletin	31
Dental Hygiene Positions Available	32



PRESIDENT'S MESSAGE

Mrs. J. Gardner

I welcome this opportunity to send a message to the Canadian dental hygienists. Our Association is very young and widespread, so that until the publication of the Journal, the communication link for all of us, often the average member has not felt that she knew the executive and what they are thinking, or realized that there can be benefits in membership in our professional Association.

From the first day in office, I have been made increasingly aware that the tremendous demands for change in dentistry is likewise demanding change in the field of dental hygiene and this is creating considerable controversy and bewilderment among hygienists. With some regularity, new pressures or demands are placed upon the office of President to answer in terms of you, the Canadian hygienists, what changes should be made - how they are to be made. It would appear therefore, that even though the Canadian Dental Hygienists' Association is still in its formative, organizational years, we are being called upon to come up with some mature, experienced thinking on - the expansion of duties; - the dental hygienist's role in the future in dentistry; - dental hygiene education. These answers are not expected to come at some indefinite time in the future, but they seem to be wanted today. I feel that every member, every practicing hygienist must participate in finding "tomorrow's answers today".

Since May, two personal thoughts have crystallized for me. First, it is my personal view that the role of the hygienist should remain strongly preventive oriented. W.E. Brown, Jr. DDS, Ann Arbor, Michigan, states in the October ADA Journal, "If dentistry is to approach its full potential, it must focus more precisely on prevention." Dental hygiene has a long history and experience in the field of prevention. Since this is so, "Expanded duties" could be interpreted to mean more effective utilization of the abilities and knowledge our present training gives us. I am in agreement with those who express the view that expansion should come in the field of periodontia, prevention and treatment. Deep scaling; root planing and polishing; preparation, placement and removal of periodontal packs; knowledge for recognition of occlusal problems in both children and adults seem a logical move forward and one in keeping with our present role. Already, extended or expanded range of duties are being taught in several schools of dental hygiene in Canada to enable hygienists to perform some services in the specialty fields of dentistry; orthodontics - prosthetics - periodontics. I'm sure that we are all aware that the demand for change may not allow us to remain "status quo", but I hope that there will be no move to have our role drastically changed, that the role of prevention will not be minimized or lost. Effective utilization of the dental hygienist can lead to a better dental service.

Secondly, these same changes in dentistry that require us to take a look to the future of our role, would also indicate the necessity of looking to our education. There is a need for degree programs in dental hygiene in addition to the present two-three year programs available, to educate teachers and administrators. Equally important there is reason to look into developing a continuing education program so that graduate dental hygienists can be in step with the profession of the future. Not enough are available in Canada. Advances in new techniques, knowledge and the competition from other auxiliaries indicate that there is a real need for such courses in order to pre-serve and maintain our position on the dental health team. It is my hope that through the Education and Recruitment committee of the CDHA, both on the constituent level

and nationally, that there will be work done towards implementation of such a continuing education program.

It is my good fortune to have enthusiastic and willing workers in the executive positions, committee chairmen and committee members to share the responsibilities in this time of decisions. I now ask that you share this with us. In the days of the stage coach, when the coach would get in trouble on a rough road or going up a hill, 1st class travelers could remain in their seats, 2nd class had to get out and walk, but the 3rd class passengers had to get out and push. In our Association, you must all be third class members and as such be willing to get out and push whenever we undertake to put over some project or arrive at a decision that will affect our profession.

EDITOR'S MESSAGE

Mrs. Patricia Kerr,
Editorial Chairman

Let me first say 'welcome' to the first of what I hope will be countless issues of The Canadian Dental Hygienist. Our association has been waiting for an official publication for many years, and my committee and I are happy to present this one as a starting point. At this time, too, I would like to say to Bonnie Snowdon and Carol Ono, who put together the summer supplement containing the business of the May, 1967, C.D.H.A. convention in Toronto, that their publication was much appreciated. We have received many compliments on it -- thanks for breaking trail, girls.

This first issue of The Canadian Dental Hygienist is being sent to all hygienists in Canada. Subsequent issues will go only to members of the C.D.H.A. as it is financed by the membership fees of the national association.

In parting, may I extend to you our best wishes for the holiday season and for a prosperous 1968. Happy reading----

Manitoba Dental Hygienist's Association will hold their Annual Meeting on January 20, 1968. This will be in conjunction with the Manitoba Dental Associations' meeting at the International Inn, Winnipeg, Manitoba.

FROM THE MEMBERSHIP CHAIRMAN

Mrs. G. Fraser,
Membership Chairman

The past five years have seen the C.D.H.A. grow from its infancy into a strong and purposeful professional Association. In May 1963 when the C.D.H.A. was provisionally constituted it was a case of putting the horse before the cart. A group of interested and devoted hygienists from across Canada met together to try to establish a national association. At this time Ontario had the only organized group of hygienists. However, within a couple of years constituent associations began to form and now the cart has 5 wheels (constituent associations) Nova Scotia, Ontario, Manitoba, Alberta and British Columbia. It is much more stable but will look forward to the day it has 8 wheels, (Saskatchewan, Quebec and the Maritime provinces). The C.D.H.A. is now the strong horse pulling the cart. In June 1966 the revised constitution of the C.D.H.A. was passed and in June 1967 the C.D.H.A. adopted its code of ethics. The wheels are now turning smoothly and the C.D.H.A. is functioning to fulfill its objectives "to cultivate, promote and sustain the art and science of Dental Hygiene, to maintain the honour and interests of the Dental Hygiene Profession; to represent and safeguard the common interests of the members of the profession and in so doing contribute toward the improvement of the health of the public."

The C.D.H.A. has represented the members of the dental hygiene profession to the C.D.A. and the federal government in the matters of the Hall Commission Report. The C.D.H.A. is working towards scholarships, scientific meetings, more effective and less expensive national insurance plans, national hygiene exams and the publishing of informative material for the public and prospective hygiene students. The C.D.H.A. has now published two excellent journals and will continue to as long as there is sufficient membership and support.

As the centennial year draws to a close and you start to think about resolutions for 1968, evaluate your professional status. Your success as a Dental Hygienist will depend upon your professional attitude, interest and knowledge of the latest techniques and research, and on your ability to apply your knowledge and skill to the practise of your profession.

A position of trust and service brings with it certain professional obligations. One of these is the responsibility of active membership in the organization that represents the dental hygiene profession. In this way the individual can most effectively work for the furtherance of her profession and contribute to the health and welfare of her community.

Membership forms for active membership are available from Constituent Treasurers. Forms will be sent to non-constituent dental hygienists and dental hygiene students early in December for associate and junior membership.

A STUDY OF FOUR DISCLOSING SOLUTIONS

J.M. Downton*, R.D.H. and
C.R. Castaldi**, D.D.S., M.S.D.

Twenty years ago John Knutson and co-workers demonstrated that a dental prophylaxis enhances the effect of topical fluorides. (1) Since that time the search for improved methods for obtaining a cleaner tooth has proceeded in two directions. A new abrasive zirconium silicate (Y), of a particular particle size, has been found to be better than flour of pumice as a cleaning and polishing agent. (2) In addition, various dyes have been used in the form of disclosing solutions and disclosing tablets to demonstrate the extent of the plaque and thus facilitate its removal.

Iodine, mercurochrome, bismark brown, and basic fuchsin (3) have been frequently recommended for disclosing solutions. The disagreeable taste of iodine is virtually impossible to mask and basic fuchsin has been suspect of being carcinogenic (4). In the studies undertaken by Dr. Sumter S. Arnim (5) disclosing wafers containing erythrosine are recommended. The authors have had no experience with bismark brown as a disclosing agent but it is known to be in routine use in several dental schools.

The purposes of the present report is to describe four disclosing solutions and to compare them in routine clinical use. The four disclosing solutions tested were the following:

- | | |
|-------------------------|-----------|
| 1. Mercurochrome | 4.5 gms. |
| Oil of peppermint | 2 drops |
| Saccharin | 0.1 gm. |
| Distilled water | 90 ml. |
| 2. Erythrosine | 0.8 gm. |
| Distilled water | 100 ml. |
| Alcohol 95% | 10 ml. |
| Oil of peppermint | 2 drops |
| 3. Red food colouring | 2 fl. oz. |
| Oil of peppermint | 1 drop |
| Saccharin | .05 gm. |
| 4. Green food colouring | 2 fl. oz. |
| Oil of peppermint | 1 drop |
| Saccharin | .05 gm. |

The properties of a disclosing solution which are significant are the following:

colour contrast
duration of stain - a. oral
 b. towels, clothing
patient acceptance
availability of ingredients

* Research Assistant and Clinical Dental Hygiene Instructor, U. of Manitoba.

** Professor of Pedodontics, U. of Manitoba.

Y Trade Name "Zircate", L.D. Caulk Co., Milford, Delaware, U.S.A.

Colour Contrast:

The contrast of the stained plaque with the surrounding tissues is an important factor in the choice of a disclosing solution. The mercurochrome solution was judged to give a slightly better colour contrast than the other three solutions. It was followed closely by the erythrosine solution.

Duration of Stain (oral):

With regard to the duration of stain orally, the ideal disclosing solution is one which would require but one application; that is it would continue to be effective until the prophylaxis was completed. Individual preference as to how a disclosing solution is used could be a factor in the choice of the solution from the standpoint of the duration of the stain. If the operator could perform a reasonably good prophylaxis without a disclosing solution then the solution could be used only to check the effectiveness of the prophylaxis at its conclusion. Under such circumstances all of the solutions performed reasonably well. However, disclosing solutions are also used as aids in patient education prior to the removal of the dental plaque. Our method for choosing the longest lasting stain involved the application of the solution prior to any cleaning procedure. Figures A, B, C, D, E, and F (shown on page 8) illustrate the duration of stain for all four solutions. The mercurochrome solution stained the plaque for the longest period of time followed by the erythrosine solution.

Duration of Stain (towels, clothing):

The mercurochrome solution which gave the best colour contrast and stained the plaque for the longest period of time was the worst of the four solutions for staining towels, clothing, etc. In fact, it was the only solution which was still visible after a test towel was purposely stained with all four disclosing solutions and then sent to the laundry immediately. If the stained towel was left overnight before laundering remnants of mercurochrome and erythrosine stain remained but the mercurochrome stain was most easily seen. The red and green food colouring solutions were the easiest to clean from the towels followed by the erythrosine solution.

Patient Acceptability:

Taste and duration of stain are factors which often evoke comments by patients. When the mercurochrome solution is used without a flavouring agent as recommended in most dental hygiene textbooks, many patients will frequently object to the taste. All the solutions, therefore, were flavoured and as such were acceptable to most patients. From the standpoint of the duration of stain however, the mercurochrome solution and the erythrosine solution rate poorly since frequently they will remain on the gingiva and lips after the patient leaves the office. In contrast to this, the red and green food colouring solutions are easily rinsed from the mouth.

Availability:

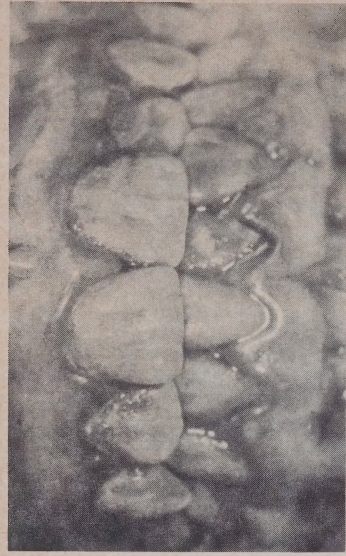
Of the four disclosing solutions tested mercurochrome can be obtained on prescription from a pharmacist. The red or green food colouring can be purchased inexpensively at most grocery stores but have the disadvantage of not being flavoured. The two flavouring agents, oil of peppermint and saccharin must be added. Erythrosine (also called F D & C #3 red) can be purchased from Allied Chemical Canada Ltd., National Aniline Products, 100 N. Queen Street, P.O. Box 65, Toronto 18, Ontario. The minimum amount that can be purchased from this source is a 1 pound container at a cost of approximately \$15.00. Such an amount of dye would last almost indefinitely if used by only one dental office. Therefore it is recommended that a number of hygienists and dentists arrange for the purchase of a one pound container through a local pharmacist who could then supply the disclosing solution as requested.



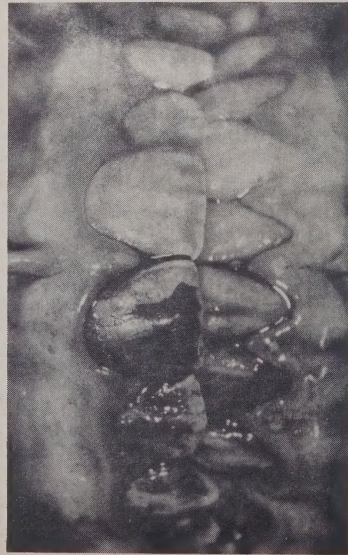
A. Erythroline disclosing solution applied to the right half of the patient's mouth, mercurochrome to the left. The mouth was syringed with water just before the photograph was taken.



B. Same case as A, after 5 minutes leaving mouth undisturbed.



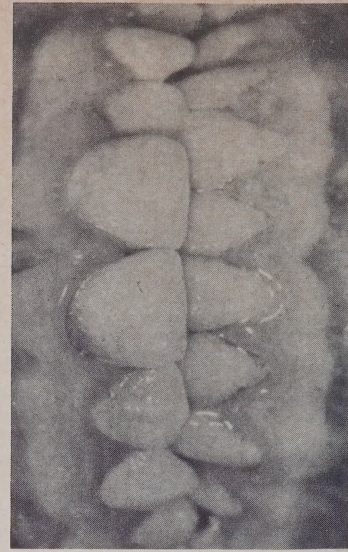
C. Same case as A, after 10 minutes undisturbed.



D. Red and green food colouring applied to opposite sides of the mouth. The mouth was not syringed with water before photograph was taken.



E. Same case as D. Mouth was syringed with water after disclosing solutions in D were applied. Mouth was then left undisturbed for 5 minutes.



F. Same case as D, after 10 minutes mouth undisturbed.

Disclosing Tablets or Wafers:

Disclosing wafers (5) are becoming more popular because of their convenience for home use. However the tablets are frequently too large and although they usually are grooved to facilitate a partial dosage it is often difficult to obtain two equally divided halves. The tablets most easily obtainable in Canada* contain erythrosine as the dye component. A disclosing solution for office use comparable to formula #2 (above) can be made from these disclosing tablets as follows:

Disclosing tablets	30
Distilled water	7 fl. oz.
(warm)	
Alcohol 95%	1 fl. oz.
(allow 1/2 hr. for tablets to dissolve)	

Discussion:

It is likely that no disclosing solution will be found which is ideal in all respects. For teaching purposes from two standpoints, the mercurochrome solution can be considered ideal because of good colour contrast and the duration of the stain orally. However, since it is very difficult to remove if spilled on towels or clothing, it must be rated undesirable. The erythrosine disclosing solution has fairly good colour contrast is of medium duration and since it does not stain towels or clothing, it is probably the most desirable of the four solutions for use in teaching clinics. From the standpoint of office practice where efficiency is of utmost importance, the use of red or green food colouring has great merit. These dyes are easily available, require no prescription and if flavoured as described in this paper, will be found a valuable adjunct to office practice. However, it must be remembered that they require frequent application due to their short time duration.

Chart I presents a summary of our evaluation of the flour disclosing solutions tested.

CHART I.
PROPERTIES OF DISCLOSING SOLUTIONS

	Colour Contrast	Duration	Availability	Staining of Towels, Clothes, etc.
Mercurochrome	X X X X	X X X X	X X X	X X
Erythrosine	X X X	X X X	X	X
Red Food Colouring	X X X	X	X X X X	-
Green Food Colouring	X X	X	X X X X	-

Summary:

Four disclosing solutions were tested in routine clinical situations. No solution was found to be ideal in all respects. A solution containing erythrosine was judged most desirable for use in teaching clinics. Red food colouring purchased from a grocery store and flavoured could be a valuable adjunct in office practice because of easy availability, low cost, short duration and lack of undesirable staining of towels, clothing, etc; frequent application however is required and colour contrast although acceptable was not ideal.

* Proctor and Gamble Co., P.O. Box 589, Hamilton, Ontario.

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NUMBER OF DENTAL HYGIENISTS CONTINUES TO INCREASE

There are almost five times as many dental hygienists in practice now as there were five years ago. Over 62 percent of the 383 national total are located in Ontario. All other provinces have at least one hygienist in practice. In Canada as a whole, there is one hygienist for every 17 dentists but as they are not evenly distributed throughout the country this ratio varies greatly from province to province. Those provinces with schools of dental hygiene - Alberta, Nova Scotia, Ontario and Manitoba - are also those with the highest ratio of hygienists to dentists.

Ratio of practising dental hygienists to licensed dentists, 1967:

Province	Hygienists/ Dentists	Number Practicing
Newfoundland	1/51	1
Prince Edward Island	1/15	2
Nova Scotia	1/10	24
New Brunswick	1/65	2
Quebec	1/221	7
Ontario	1/11	238
Manitoba	1/13	23 (estimated)
Saskatchewan	1/22	10
Alberta	1/10	50
British Columbia	1/30	26
Canada	1/17	383

YOUR CHOICE OF TOPICAL FLUORIDE THERAPY

C. R. Castaldi, D. D. S., M. S. D.,
Professor of Pedodontics, University of Manitoba

Formulae and Techniques

Precautions

Disclosing solutions and tablets.
Abrasives for prophylactic pastes.
Sodium fluoride solution.
Stannous fluoride solution.
Acidulated sodium fluoride phosphate solution.
Stannous fluoride prophylactic paste.
Multiple topical fluoride technique.
Acidulated sodium fluoride phosphate prophylactic paste.
Sodium fluoride mouth wash.
Fluoride gels.
First aid in acute fluoride poisoning.

PRECAUTIONS

In concentrated form, fluoride compounds are very toxic. Patients should be cautioned against swallowing solutions, prophylactic pastes or gels containing concentrated fluoride compounds.

Inflammation of gingival tissues:

Where there are heavy deposits of calculus and where the gingival tissues are inflamed the use of topical fluorides should be postponed until the inflammation has subsided. Ulceration of the gingivae will result if this precaution is not observed.

Prescriptions for fluoride mouth wash should be given only to cooperative patients and in the case of children, the parents or guardian must exercise responsibility and caution in the home use of any fluoride compound intended to reduce tooth decay.

DISCLOSING SOLUTIONS AND TABLETS

Disclosing solutions and disclosing tablets are used to expose deeper areas of plaque which are not visible to the naked eye. Failure to remove the plaque will hinder the effectiveness of the fluoride treatment. Use disclosing solution routinely for all prophylaxes.

Four clinically tested formulae for disclosing solutions are:

- | | |
|------------------------|-------------|
| 1. Mercurochrome | 4.5 gm |
| Oil of peppermint | 2 drops |
| Saccharin | 0.1 gm |
| Distilled water | 90.0 cc |
| 2. Green or red liquid | |
| food colouring | 2.0 fl. oz. |
| Oil of peppermint | 1 drop |
| Saccharin | .05 gm |

- | | | |
|---|-------|---------|
| 3. Disclosing tablets | 30 | |
| Distilled water (warm) | 7 | fl. oz. |
| Alcohol 95% | 1 | fl. oz. |
| (allow 1/2 hr. for tablets to dissolve) | | |
| 4. Erythrosine (F. D. and C #3 red) | 0.8 | gm |
| Distilled water | 100.0 | cc |
| Alcohol 95% | 10.0 | cc |
| Oil of peppermint | 2 | drops |

Directions for using disclosing solution:

1. Paint the patient's lips with vaseline.
2. Place 10 drops of disclosing solution in dappen dish.
3. Swab the teeth with a cotton pellet or "Q" tip dipped in disclosing solution.
4. Syringe the teeth with water; plaque will stain red (or green).
5. Give prophylaxis.
6. Check prophylaxis by reapplying solution.
7. Where stains remain the prophylaxis is repeated.

Disclosing tablets: are composed of a dye and a flavouring agent held together by a binder. The tablet is chewed for 2-3 minutes and can be swallowed. Plaques will be clearly demonstrated. Both solutions and dyes can be prescribed for home use.

ABRASIVES FOR PROPHYLACTIC PASTES

Flour of pumice
Zirconium silicate ("ZIRCATE")*

Flour of Pumice is a fairly good abrasive for prophylaxis. It is inexpensive, easily obtained and is compatible chemically with stannous fluoride solutions when made into a paste. It is not compatible with acidulated sodium fluoride phosphate solution when made into a paste; sodium silico fluoride is formed which has not proven very effective when used for topical application.

Zirconium silicate has been found to be superior to flour of pumice for cleaning and polishing teeth. It is compatible chemically with both stannous fluoride solution and with acidulated sodium fluoride phosphate solution when made into a paste.

Disadvantages of zirconium silicate: rapid wearing of the gears in the contra angle has been frequently reported. Contra angles should be scrupulously cleaned and oiled after several prophylaxes when using zirconium silicate as the abrasive.

SODIUM FLUORIDE SOLUTION

A considerable amount of research was done during the 1935-50 period to prove the decay reducing properties of a 2% sodium fluoride solution applied to the teeth. The recommended method involved a series of 4 treatments given 1 week apart. Later it was shown that an 8% solution of stannous fluoride given once every year over a 5 year period was superior to a series of four applications of 2% sodium fluoride given once every 3 years. It is possible that a 2% solution of sodium fluoride given once every six months may be as effective as a 10% solution of sodium fluoride given every six months but further research applying modern methods for caries increment evaluation is needed.

Formula

Sodium fluoride	2 gm.
Distilled water	100 c.c.

* Trade name, L. D. Caulk Co., Milford, Delaware, U. S. A.

Can be stored indefinitely in the dental office in a polyethylene or other plastic bottle. pH is about 7.0.

Method

Similar to stannous fluoride (below) but should be applied for four minutes.

STANNOUS FLUORIDE SOLUTION

More studies have been done on stannous fluoride* for topical application than any other fluoride compound. Most of these studies report that decay reductions in children are approximately 30-40 percent and approximately 20 percent in adults. Stannous fluoride has demonstrated decay reductions in deciduous teeth and also in patients who reside in communities which have fluoridation. The pH of a 10% solution is about 2.5.

Formula

Stannous fluoride	1 gm.
Distilled water	10 c.c.

Place in plastic container and shake vigorously before using.

Method

1. Swab the teeth with disclosing solution.
2. Do a careful prophylaxis to remove all calculus and plaque.
3. Check for thoroughness of prophylaxis by re-applying disclosing solution.
4. Isolate the teeth with cotton rolls and dry with air.
5. Paint the teeth with 10% stannous fluoride solution for 1 minute.
6. Caution the patient to avoid rinsing the mouth for 30 minutes after treatment if possible.

The disagreeable taste of stannous fluoride can be masked by smearing the teeth with a fluoride containing dentifrice just prior to removal of the cotton rolls.

Advantages: considerable research to prove effectiveness, application time short, mild staining of early carious lesions helps indicate effectiveness.

Disadvantages: tastes disagreeable, unsightly staining of some early carious lesions when prophylaxis and/or home care are carelessly done.

ACIDULATED SODIUM FLUORIDE PHOSPHATE SOLUTION

Laboratory and clinical studies have shown that more fluoride is taken up by the tooth when acidulated sodium fluoride phosphate solution is used than when either stannous fluoride or sodium fluoride is used. However few clinical studies have been reported to date and the superiority of this solution over other fluoride solutions has not been clearly demonstrated. No studies using acidulated sodium fluoride phosphate solution have been reported on adults and none have been reported on subjects who are using fluoridated water.

Formula

To approximately 700 c.c. of distilled water, in a litre plastic graduate, add 20 gm. of sodium fluoride (reagent grade). When dissolved, add 6.3 c.c. of concentrated ortho-phosphoric acid (85% re-agent grade), 5.9 c.c. of concentrated hydro-

* The research on stannous fluoride led to the development of tooth pastes containing stannous fluoride (Crest, Cue, Fact) which have demonstrated effectiveness in reducing tooth decay. Best decay reductions obtained from these tooth pastes occur when teeth are cleaned after each meal and before bed.

fluoric acid (50% re-agent grade) and make up to 1 litre with distilled water. Mix very thoroughly. The stock solution must be kept in a screw-capped, polyethylene bottle (glass bottles should not be used) and dispensed in a small plastic container for use with patients. The stock and dispensing containers should be tightly capped when not in use. The solution is stable indefinitely.

Method

Similar to stannous fluoride (above) but solution must be applied for three minutes.

Advantages taste not objectionable, no staining, solution stable.

Disadvantages Thus far, very limited clinical research on children, no demonstrated effectiveness in adults, no clinical studies in communities which have fluoridation. Severe etching of glass (mirrors, brackets, operator's glasses, etc.).

STANNOUS FLUORIDE PROPHYLACTIC PASTE

Caries reductions of approximately 20-30 percent have resulted from the use of a prophylactic paste made from a 17% stannous fluoride solution. Effectiveness has been demonstrated on children and adults and where there is fluoridated water. Kits for making stannous fluoride prophylactic paste are available from two commercial sources in Canada*. A formula for stannous fluoride prophylactic paste based on that used by the United States Air Force is as follows:

Solution

Dissolve 25 gms. of stannous fluoride in 100 c.c. of distilled (deionized if possible) water in a 200 c.c. volumetric flask. Add 16 c.c. glycerin and mix well. Add 3 c.c. of oil of peppermint or 3 c.c. oil of wintergreen. Bring flask to 165 c.c. with distilled (deionized if possible) water. Store in plastic bottle. The solution has a concentration of about 15% SnF_2 . Considerable shaking is required to put the ingredients into solution. An oily film of flavouring agents will remain floating on the surface. Shake mixture thoroughly before using. A used plastic liquid detergent bottle with a snap on plastic cap, rinsed of all detergent several times with hot water and then dried, can serve as a convenient dispenser for the concentrated solution. The solution should be stored in a refrigerator if possible. Shelf life unrefrigerated is about 2-3 months.

Prophylactic paste

To 1 c.c. of above solution add flour of pumice or "ZIRCATE" to make a thick paste. Use a plastic alginate dispenser for a dappen dish. Apply a disclosing solution to the teeth as a routine to assure a good prophylaxis.

Precaution

Where there are heavy calculus deposits and inflamed gingivae the use of this paste should be postponed until inflammation has subsided. Ulceration of the gingivae will result if this precaution is not observed.

Method

1. Apply disclosing solution to the teeth.
2. Clean several teeth at a time with prophylactic paste. Caution patient not to swallow paste.
3. Rinse mouth with water at frequent intervals.
4. Check efficiency of prophylaxis with disclosing solution.
5. Use unwaxed silk floss to force prophylactic paste between the teeth.

* Western Metallurgical Ltd., 14445-116 Avenue, Edmonton, and
L.D. Caulk Co., local dental supply house.

MULTIPLE TOPICAL FLUORIDE TECHNIQUE, "DOUBLE FLUORIDE TREATMENT"

Recent studies involving both children and adults have shown that the combined use of a stannous fluoride prophylactic paste, 10% a stannous fluoride topical and the home use of a stannous fluoride tooth paste will give caries reductions in the range of 65-75%. When a stannous fluoride prophylaxis is combined with a 10% stannous fluoride topical in a fluoridated community the caries reductions are in the range of 80-85%.

Method

1. All calculus is removed from the teeth.
2. The teeth are swabbed with disclosing solution.
3. The teeth are cleaned with stannous fluoride prophylactic paste.
4. The mouth is rinsed with water.
5. The procedure is repeated until all plaques are removed.
6. The disclosing solution is re-applied to check on the removal of all plaques. This step is very important. Any remaining plaque must be removed by re-applying the prophylactic paste.
7. Prophylactic paste is carried through all contacts with unwaxed silk floss.
8. The mouth is thoroughly rinsed, the teeth are isolated with cotton rolls and dried.
9. 10% stannous fluoride solution is applied to the teeth for 1 min. or acidulated sodium fluoride phosphate solution is applied for 3 min.
10. The patient is advised to avoid rinsing the mouth for at least 30 min. (is possible).

ACIDULATED SODIUM FLUORIDE PHOSPHATE PROPHYLACTIC PASTE

A prophylactic paste containing acidulated sodium fluoride phosphate can be made by adding "ZIRCATE" to acidulated sodium fluoride phosphate solution for a thick paste. However no studies have been reported on the effectiveness of such a prophylactic paste. A number of commercial preparations are also available but none have been tested for effectiveness in reducing caries. When acidulated sodium fluoride phosphate solution is mixed with flour of pumice to form a paste, sodium silico fluoride is formed. Sodium silico fluoride solution has not been found to be very effective for topical application.

SODIUM FLUORIDE MOUTH WASH

Sodium fluoride mouth washes have proven very effective in reducing caries in studies involving groups of Swedish school children. One formula was used daily and another every two weeks. These mouth washes should not be prescribed for home use unless parental cooperation is assured.

Sodium fluoride mouth wash (0.2%)

Use once every 2 weeks

R_x

Sodium fluoride	0.2 gm
Distilled water	100 c.c.

Directions - Rinse mouth with 3 tbs. of mouth wash for 10-15 seconds once every 2 weeks after brushing teeth carefully after supper.

Caution - Store out of reach of small children.
Do not use for pre-school children.
Carefully supervise young school age children.

Sodium fluoride mouth wash (.05%)

Use Daily

R_x

Sodium fluoride	0.2 gm
Distilled water	400 c.c.

Directions - Rinse mouth with 3 tbs. of mouth wash for 10-15 seconds daily after brushing teeth carefully after supper.

Caution - Store out of reach of small children.
Do not use for pre-school children.
Carefully supervise young school age children.

FLUORIDE GELS

The only study which has demonstrated a caries reducing effect from fluoride gels involved the daily use of a sodium fluoride gel (pH 7.0) or an acidulated sodium fluoride phosphate gel (pH 4.5) for a period of 21 months. The children were age 11-14 and the gel was applied in custom made maxillary and mandibular mouth guards similar to those used for protection in contact sports.

Formula

Sodium fluoride	1.1 gm
Distilled water	100 c.c.
Oil of peppermint	2 drops
Saccharin	0.1 gm
Hydroxypropyl methyl cellulose gelling agent	3.0 gm

Method

5-10 drops of gel is placed on inner surface of mouth guard and spread evenly with a brush. The mouth guard is inserted for 6 minutes and any spillage of gel from beneath the mouth guard is spit into the sink or paper towel. After the applicators are removed the mouth is rinsed with tap water and the mouth guard is rinsed with water and placed to dry.

FIRST AID IN ACUTE FLUORIDE POISONING

The initial symptoms in acute fluoride poisoning are salty or soapy taste, increased salivation, nausea, abdominal cramps, vomiting, diarrhea (may be bloody), dehydration and thirst. THE MOST PRACTICAL SUGGESTION FOR FIRST AID TREATMENT IS TO HAVE THE PATIENT DRINK COPIOUS QUANTITIES OF MILK OR FAILING THIS, RAW EGG WHITE GIVEN ORALLY. VOMITING SHOULD THEN BE INDUCED AT ONCE AS FOLLOWS: the index finger is placed far back on the tongue and stroked from side to side. Repeat until vomited fluid is clear. In cases of large overdosage the patient should be hospitalized and intravenous infusion of glucose in isotonic saline should be started. 10 ml. of 10% calcium gluconate solution is injected into the running I.V. tube and this is repeated in about 1 hour or if tetany appears. Gastric lavage should also be instituted using lime water or 1% calcium chloride. Several ounces of lime water are given orally at frequent intervals. 10 ml. of 10% calcium gluconate are given intravenously every 4-6 hours until recovery is complete. Shock is treated in the usual manner.

NOTE Bibliography can be supplied on request.

"SENIOR DENTAL HYGIENIST" - a new position

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Introduction:

I have undertaken to write a short article concerning my experience as a dental hygienist. Since the sheer proximity of the present looms largest in my mind, I have chosen to center my discussion around the new position of Senior Dental Hygienist which I am presently occupying. However, due to the fact that I have filled the position only a short time, I must limit this present discussion of the Senior Dental Hygienist position to that of description rather than concrete plans and accomplishments. First, I wish to discuss two topics - excellence and knowledge - which will lead me into the description of the position of Senior Dental Hygienist.

The Pursuit of Excellence:

When I began to think of the main theme for this article I immediately turned to a book which an instructor from Columbia University had given me.* The author, now the Secretary of the United States Department of Health, Education and Welfare, presents a very great challenge to each and every one of us who has a vested interest in the dental health of our fellow countrymen. The challenge is to pursue excellence - a motivation which is desirable for each and every group in society whatever its present status, whether elevator operators or surgeons. With this pursuit of excellence, of course, must go the ardent and persistent pursuit of knowledge to which I now wish to turn.

Knowledge:

Accurate up-to-date information is an essential to good decision-making policies regarding any group. As a group such as dental hygiene develops and expands in structure and numbers, the body of information on this group becomes increasingly larger. In government, for example, this progression may lead to the creation of 'advisors' or 'consultants' who in essence provide information and advice on their specified area of knowledge to the senior persons who will use this information in decisions which they may be required to make. Much of the Senior Dental Hygienist's role involves this very thing - liaison with the organizations involved with dental hygienists - the dental hygiene associations, the faculties of dentistry, the public health departments within the provinces, and continuous consultation within the government structure. The Senior Dental Hygienist in general advises the Chief of the Dental Health Division, Dr. R.A. Connor, in all matters pertaining to dental hygiene.

The General Aims of the Dental Health Division:

The work of the Dental Health Division is directed toward the improvement of dental health in Canada, through co-operation with provincial departments of health, the Canadian Dental Association and its related professional groups, the dental schools, dental research bodies, and all other interested organizations.

The Role of the Senior Dental Hygienist:

The position of Senior Dental Hygienist has been newly formed by revision of the pre-existing dental hygienist position. Previous to this present position, dental

* Gardner, John W., "Excellence Can We Be Equal and Excellent Too?"
Harper and Row, New York, 1961.

hygienists were employed by the Dental Health Division in various clinical, technical capacities with a more limited degree of scope with regard to dental hygienists across Canada. The role of the Senior Dental Hygienist can be grouped into three main areas - performance in an advisory and liaison capacity concerning dental hygienists in Canada, and performance in auxiliary capacities in two concerns of the Division - dental health education and research.

Under the direction of the Chief, Dental Health Division, the Senior Dental Hygienist serves as Consultant in Dental Hygiene within the department and to the government departments and agencies, especially the provincial departments of health; to advise the Chief and others as required, on the recruitment, training, and effective employment of dental hygienists in both private practice and public health. She is also available to provide consultation to, and liaison with faculties of dentistry and associations of dental hygienists. The incumbent assists the Dental Health Officer of the Division in the development of dental health education materials and aids the Dental Research Officer of the Division in intramural research, and the stimulation and conduct of extramural research involving dental hygiene.

Past Experience and Education:

I have had a sampling of three areas involving dental hygiene - private practice, teaching (at the University of Alberta), and public health in Jasper, Alberta. My education in dental hygiene was gained at Columbia University in New York City. Columbia has three different programs from those available in Canada at the present time, and these will be of interest to any dental hygiene graduate from Canada considering further education in the dental hygiene area. I took the program where two years of arts and science subjects are required before a two-year dental hygiene course is taken to graduate with a Baccalaureate of Science in Dental Hygiene. There is also a program for graduates of two-year dental hygiene courses, such as ours in Canada, who wish to take an extra two years of a combination of advanced dental hygiene subjects, clinical teaching courses, and liberal arts and science courses to complete the requirements for a Bachelor of Science Degree in Dental Hygiene. Graduates of this program often pursue or continue a career in the teaching of clinical dental hygiene subjects.

The third program which I completed this past June is a Master's program, one academic year in length, for dental hygiene graduates with Bachelor degrees who are interested in dental hygiene education - teaching in a school of dental hygiene, administration in public health programs, or research. Many of the students in this program have had previous experience in the teaching of dental hygiene subjects.

Conclusion:

There is evidence in the present situation that graduate and post-graduate education in the field of dental hygiene is to be encouraged. The motivation is an idealistic but very attainable one - the pursuit of excellence. It is hoped that the labours of a challenging graduate and post-graduate education will reap rewards in what these individuals will have to offer to the profession of dental hygiene in Canada. The position of Senior Dental Hygienist in Ottawa adds another place where dental hygienists can give their support to dentistry in their continuing efforts to improve dental health in Canada.

DENTAL HYGIENE PRACTICE IN NORTHERN CANADA

Miss Ginny Bax, R.D.H.

Dental Hygiene among ice, snow, Northern Lights, and Eskimos; that's Dental Hygiene in the North West Territories. A year ago, as I decided to see what the North was really like instead of merely reading about it, I had no idea just what my stay would bring. Now, an "old-timer" in Frobisher Bay, I'm still amazed by some of the things I see and do. Yet I can already recall many unusual experiences.

To orient those who aren't sure, Frobisher Bay is on the southern end of Baffin Island, about 190 miles below the Arctic Circle. It's a community of about 1700, two-thirds of which are Eskimo, and it boasts most of the facilities that any small town in the South does.

I caught my first glimpse of Frobisher Bay at the unfortunate hour of 5:00 A.M. as the plane circled and landed in a world of white. Results of the season's last snow storm made me shiver as I thought of balmy Temperatures and green grass left behind in Montreal. However, it was Spring, even in the North, and soon the snow was gone and the hills became green with moss. Temperatures soared to the 50 and 60 degree mark, often making it very tempting to leave the work and go fishing, a sport everyone takes up for the short season.

At first my work was a private practice arrangement with both the Dentist's and my office at the Hospital. As with anything new, (as a Dental Hygienist was in Frobisher) my service had to be promoted, and promoted it was, by the Dentist, Hospital staff, and by the local radio station. I soon was greeted, upon introduction, as "the girl advertised on the radio". A bit disconcerting at times, but nevertheless, effective. By the time I began working in the schools, in September, I was an accepted member of the health, and general community.

Time passes quickly here and the summer months, broken by working trips to settlements, were no exception. My first such trip was to Broughton Island, a small settlement just off the Northern coast of Baffin Island... about two and one-half hours flying distance. Not having much of an idea what I was going to, I donned my parka and rubber boots (standard dress), packed portable equipment, and waited, surrounded by cargo, for the aircraft to depart. While waiting, I was a bit unnerved by numerous cheerful, but sympathetic, persons who passed by inquiring where I was going, why, and how. When they learned how, everyone of them wished me luck, and I learned the small two engine plane had crashed several times and seemed somewhat of a jinx. I was beginning to have serious doubts about the whole situation. Once airborne, however, all apprehension vanished as I viewed the craggy, cold-looking mountains, my first glacier, and an iceberg which was used as a flying guide. We flew up a fiord part way, with the sides of the mountains rising up so close to the wing-tips it seemed we'd brush them at any moment. Still, an interesting flight.

When we landed at Broughton Island we were met by the village children who swarmed across the tundra, and by the rest of the welcoming committee in an old Bombardier. It was a temperamental old machine equipped with wheels for summer, and it smoked and rattled at every turn. That was "A-go-go '67".

For the next week then, the Nursing Station was "home" as I worked my way through the children still in the settlement; many had already left for the summer camp, some miles distant. With the Nurse, I visited Eskimo homes, complimented hunters on their seal catch, and watched as the women nimbly scraped fresh skins and hung them on a line, like laundry, to dry. We both saw patients from noon until evening as these people stay up until very early morning and then sleep late. This was truly the "Land of the Midnight Sun"; at midnight the sun still hung high in the sky.

After a week the fog, which had made flying impossible, lifted and I returned to Frobisher on a plane carrying visiting Russian researchers. This time we flew over the Barry Highlands, an icecap on the mountains in the middle of Baffin Island. Here the altitude is so high the snow never melts, and it was a dazzling sight to see the plateau of snow....miles and miles of perfect whiteness without a blemish.

Back in Frobisher Bay, summer was in full swing, both nature-wise and activity-wise. The hills were green with moss; the flowers were blooming, purple, pink, yellow, white; the river falls were unfrozen so the Arctic Char were beginning to bite. Activity-wise, there were scores of interesting people doing unusual things. There were mountain climbers, whale and seal researchers, fish counters, wolf studies, ice-patrol teams, students in everything, and a few people on vacation. We even prepared for a visit by the Crown Prince of Belgium!

By this time it was July and we were planning a tour of settlements on the northern coast of Baffin Island. The Dentist, Public Health Nurse, and I spent two weeks working at three settlements. Our first step was to Resolute Bay on a cold, wet, windy day. Immediately we decided anyone would have to be resolute to stay there! The horizon was a desolate stretch of sand and gravel with the only color being the orange Department of Transport buildings. No women are at the Base itself, and the Nurse and I encountered several problems in accommodation in a place not equipped for, nor expecting, them. However, the hospitality compensated the inconveniences and we thoroughly enjoyed the fresh fruits, cheeses, and drinks in bottles, not cans. These are delicacies in Frobisher Bay.

Pond Inlet, with its magnificent scenery, was our first working stop. The mountains are perfect conical shapes and were, of course, snow capped. Right across from the settlement was Bylot Island and its twin peaks, the Castle's Gables, and huge glaciers. This is the scene depicted on the 15 cent stamp issued this summer. Looking at the bright green grass and the soft purple mountains, one would hardly think we were two thousand miles north of Montreal. The ice still on the bay, though, was a reminder.

We became very aware of this ice on our canoe trip from the beach landing strip to the settlement. Our Eskimo driver steered the boat carefully between the labyrinth of ice then, able to go no farther, we all jumped out, lugged it across the pan to the next patch of open water, and scrambled back in quickly before the ice sank. Because it was in floes, or pans, which floated loosely, we had to be careful they didn't sink while we were on them. Everyone, in spite of precautions, acquired at least one wet foot. The theory is that a body can last only two to three minutes in Arctic water and, since I wasn't too eager to prove it, I kept one foot in the boat at all times!

Included in our trip was Arctic Bay where we met Atoot, about seventy years old. She was the oldest person in the settlement and was covered with tatoos which had made her, in her youth, one of the village beauties. There, we "set up shop" in a vacant house and our unorthodox office was constant, moving confusion as the whole community came to watch us work. It was a notable social event to the Eskimos.

Grise Fiord was the last point in our travels. It holds the undeniable claim to being the most northerly settlement in Canada, except for weather and radio stations. There, in July, ice was still heavy on the sea and icebergs were a common sight. You can image our surprise when we saw Eskimo children swimming in a small lake behind the village! They just tossed off their parkas and rubber boots and splashed in, then ran home for dry trousers. Because there was still so much ice it was impossible to use the boats for hunting. The men and boys sat on the beach and waited for the seal to come to them; they would wait for hours for an unwary seal to poke its nose up. As well as patience, Eskimo people have a tremendous sense of humor, as shown when Philipoosee, an old carver, jokingly told us the stone he was carving was to be a frozen seal standing on its tail. Although we were quite certain it really wasn't, he wouldn't satisfy our curiosity. Carving and hunting are these peoples' means of earning money, and while we were there we saw the results of the winter's hunting trips. The polar bear and musk-ox skins hadn't been sent South yet so buying one there was like shopping at a super market, there was such a selection! When we left Grise we went on the "sched. flight", one scheduled each six to eight weeks, weather permitting, which

takes mail and goodies in and out of the settlement. You can imagine how much cargo came and how eagerly it was received! No one complained at all about the four mile hike to the beach strip even though it was over tide ice, rocks, and spongy moss.

As visitors along the way we brought with us fresh food, news from "the South", and variety to the outposts. In return we had a taste of Northern living, and that was a taste, literally. We dined on caribou steaks, seal liver, and Arctic Char. For a snack, how about bannock and muktuk? Muktuk is the epidermis of whale, a grey, rubbery substance which is chewed like gum. Having picked enough of it from children's teeth I wasn't too enthusiastic about it, so I just chewed once and swallowed quickly. However, it has no taste so my worst fears were groundless.

Once again we returned to a Frobisher buzzing with activity. The annual sea-lift had begun. Nearly every week there was another boat to be unloaded as supplies came in for the year. This is a time of year eagerly awaited by all as new vehicles, prefab houses in packages--everything imaginable--, arrived. Most welcomed I'm sure was the boat bringing fresh food. Very appropriately, it came in just before Thanksgiving, saving us from a Thanksgiving dinner of perhaps tough porkchops and macaroni.

And so, Frobisher Bay prepares for winter; with sea-lift come and gone, new parkas and kamiks made, and the new-comers of the everchanging population settled and welcomed. The orange posts along the roads are brightened up for easy spotting during storms, and extra heating plugs are installed for vehicles. It's a long, dark winter, but an interesting one, and time passes quickly here.....

DENTAL PERSONNEL IN CANADA 1967

Bureau of Economic Research, CDA

DENTAL MANPOWER HAS GROWN MORE SLOWLY THAN POPULATION

Over the past decade which has seen a 24.5 percent increase in population, the number of dentist has risen 19 percent. Prince Edward Island, in fact, has 12 percent fewer dentists now than in 1957 while the province's population has increased 10 percent over the same period. The number of people per dentist in this province is therefore, 24 percent greater now than in 1957. Among the other seven provinces showing increases in population per dentist are Ontario (8 percent), New Brunswick and Quebec (6 percent), and British Columbia (4.5 percent). Newfoundland and Nova Scotia are the only provinces which have increased their dental supply at a faster rate than their population (and the apparent improvement in the latter province is due to a change in the method of reporting the number of licensed dentists).

These figures should not be examined, however, without taking into consideration the sizable increase in dental productivity over the past decade. This increase in productivity alone would probably have enabled Canadian dentists to keep pace with the additional demand for their services caused by the growth in population.

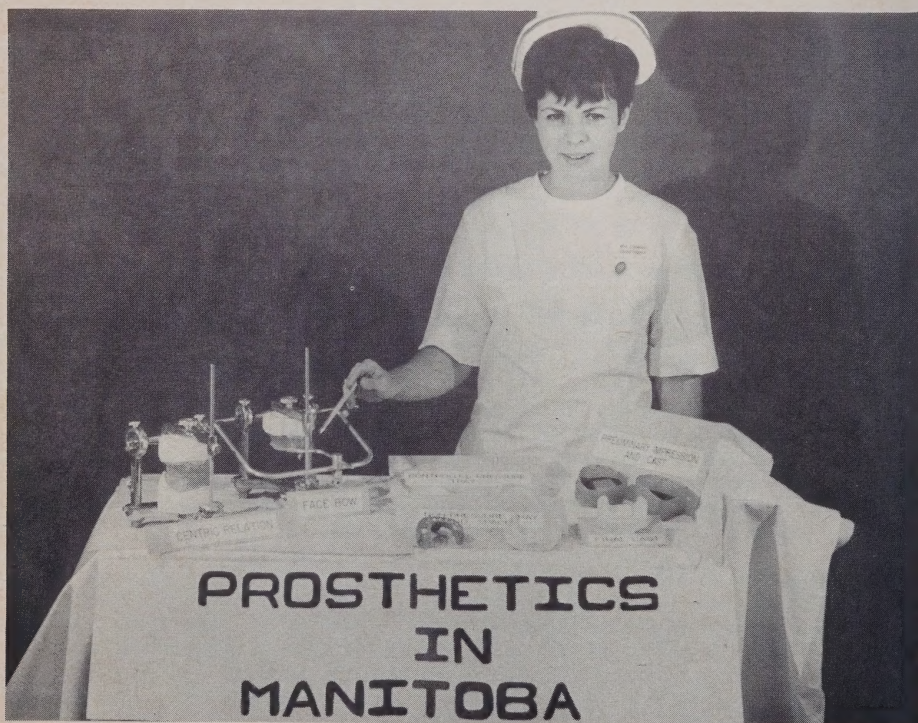
THE WESTERN CANADIAN DENTAL HYGIENE CONVENTION

This convention, October 8 - 11, 1967, was held in conjunction with the Western Canada Dental Convention in Regina, Saskatchewan. My first words on the convention must be 'congratulations for a job well done' to the handful of Saskatchewan girls who hosted the gathering. These girls as yet have no constituent association, so their work was made all the more difficult. Total attendance at the W.C.D.H. convention was close to 30; 12 of whom were the senior class of Dental Hygiene from the University of Manitoba.

To give you a brief idea of the schedule, some of the highlights included: a panel discussion, a luncheon, football game for the sports enthusiasts, a discussion of the etiology of dental caries, a presentation on the necessity for a Canadian dental hygiene association, and, as usual, dinner and dancing in the evening. You will find some of these presentations throughout the journal.

We were very fortunate that the guest lecturer of the dental convention, Dr. S.S. Arnim, B.A., D.D.S., Ph.D., from Houston, Texas, was speaking on a topic familiar to all hygienists -- 'Preventive Dentistry'. Due to the length of his presentation we have not been able to reproduce it in *The Canadian Dental Hygienist*. However some key points that Dr. Arnim mentioned were: the use of disclosing solutions, the use of irrigators for periodontal problems, the use of the phase microscope in examining plaque specimens, and the analysis of oral organisms.

Dr. W. McPhail, whose topic to the hygienists was 'Etiology of Dental Caries' was very interesting and informative. He went right back in history to show the development of this widespread disease.



Miss J. Downton



Left to right - Miss I. Mulroy, Miss B. Walker, Miss S. Mouflrier
Table Clinics presented at the Western Dental Hygiene Convention.

One of the highlights of the convention was a table clinic presentation - there were four clinics:

- 1) A Dental Hygienist in Your Office - Miss J. Sanders, Vancouver, B.C.
- 2) Prosthetics in Manitoba - Miss J. Downton, Winnipeg, Manitoba.
- 3) Periodontal Pack in Scaling Techniques - Miss D. Leggitt, Regina, Sask.
- 4) Long vs Short Cone Padiographic Techniques - Miss B. Walker, Miss I. Mulroy, Miss S. Mouflrier, 2nd year D.H., U of M.

One point that could be mentioned is that the table clinics were scheduled at a time when the dentists were attending a session, so that only a few of them saw our presentations. However, all the clinics were excellent.

A panel of two dentists and two hygienists discussed 'What is in the Future for a Dental Hygienist'. Many good points were made, and the general post-discussion feeling was that there is much room for expansion in the field of dental hygiene. Lots of food for thought, in any case.

Because of the Saskatchewan provincial election, the President's ball had been moved forward from Wednesday to Tuesday evening, ending the convention at Wednesday noon. Everyone went home feeling a little tired, but it must be agreed that the discussions during this three day meeting made all the attendants a little more aware of what is happening in the broad field of dental hygiene today.

WHAT IS IN THE FUTURE FOR THE DENTAL HYGIENIST

Miss L. Pollard

When dental hygiene educators meet to discuss the future role of the dental hygienist, two opposite points of view are invariably expressed. There are those educators who see the role of the future hygienist expanded to include a number of duties beyond the so-called "traditional" duties for which she is presently trained. These traditional duties, largely preventive in nature, include charting and history-taking, radiographs, prophylaxis, topical fluoride application and patient education. Impressions for study models and polishing restorations can now be included as part of the present duties of the hygienist since most Canadian Schools of Dental Hygiene teach these procedures within their curriculum.

Conversely, there are those educators who see for the future hygienist a greater utilization of the services for which she is presently trained. They look to the day when every patient will receive a prophylaxis, bitewing xrays, topical fluoride application, and patient education on a regular basis. These educators fear that extending the duties of the hygienist into other areas of dentistry such as prosthodontics, orthodontics and restorative dentistry would be done only at the sacrifice of her traditionally preventive role.

There are still others who see for the future hygienist, not only a further utilization of her present duties but an extension of her duties as well. The School of Dental Hygiene at the University of Manitoba has carried out experiments in both these areas. Since the School began in 1964, two programs have been introduced in an attempt to improve the utilization of a hygienist's services. The first program, adopted in 1965, took the form of an orientation program for practicing dentists. A general practitioner, who had employed a hygienist in his own practice, and members of the teaching staff of the School of Dental Hygiene participated. Many dentists who attended this orientation program and were convinced of the advantages of employing a hygienist portrayed a natural unwillingness to try new ground.

This led, perhaps indirectly, to the establishment of a second program designed to improve the utilization of a hygienist's services. It was felt by both the Faculty of Dentistry and the School of Dental Hygiene that it would be better to train dental students while they were at school to "work with" and "delegate to" a hygienist. As a result, each senior dental hygiene student was assigned to two senior dental students with the idea that the senior dental student would learn to delegate certain duties to a dental hygiene student. The dental student, as leader, would assume the responsibility of seeing that these duties were carried out. It is difficult to accurately evaluate the success of this program since it has been in operation only a short time. However, it is hoped that this program will familiarize the dental student with the role of the dental hygienist, and that in turn, the dental hygiene student will learn the role she must play in the overall dental treatment of the patient.

In the realm of extended duties Manitoba has experimented in two areas: prosthodontics and orthodontics. Dental hygiene students in their second year at the University of Manitoba receive a program in the area of complete denture prosthesis. This began as an experimental program in the fall of 1964. As a result of a study completed in June, 1965 by Doctors Richardson and Abbey, it was shown "that a dental hygienist could be trained in a reasonable time to perform to a high standard, certain delegated prosthodontic procedures." (1) The legislation which allows a hygienist to

* Presented as part of a panel discussion at the Western Dental Hygiene Convention, October 11, 1967, Regina, Saskatchewan.

(1) Lt. Col. L.A. Richardson, D.D.S. and Dr. D.S. Abbey, Ph.D., Prosthodontics for Hygienists (Winnipeg: University of Manitoba, 1965), p.1

legally perform these procedures appeared in 1960 in the form of an ammendment to the Dental Association Act. This ammendment states that a dental hygienist may be allowed:

1. to make impressions of the mouth from which artificial dentures can be made
2. to determine and record the relationship of one jaw to another.

A total of 308 hours is devoted to the teaching of these procedures. This includes lectures, pre-clinical laboratories and clinical experience. During this time the students are instructed to make preliminary impressions, final impressions, to record jaw relationships and to make impressions for study models. Three classes have graduated to date trained in this program. As a result of a questionnaire circulated in 1966 to 18 practicing hygienists of Manitoba trained in this field, the following information as learned about the utilization of this service:

1. Only 4 out of the 18 in practice did any prosthodontic work.
2. Of this 4, the percentage of time spent on this type of work ranged from a high of 40% to a low of 1%.
3. Eleven of the 18 girls took impressions for study models on the average of 1 to 5 impressions per month.
4. Of the 18, 14 answered they would like to do more work in this area because:
 - (a) they enjoyed it
 - (b) it gave their work in the dental office more variety.

Although little prosthodontic work has been done by graduate hygienists to date there is reason to believe that this type of work will increase in the future. Dental hygiene is still a relatively new profession in Manitoba; because of this many hygienists find that most of their time is occupied with the prophylaxis, topical fluoride, xrays and patient education. This leaves little time for prosthodontic work. However, as patients are seen more regularly and the work load lessens, it is likely that more time will avail itself for this type of work. Dentists are also undergoing a learning process in order to make the best use of this service as performed by the hygienist. Probably the greatest significance of this program is to be found for dental hygiene educators. It illustrates that a program such as this can be incorporated into an existing dental hygiene curriculum without extending the program beyond its two academic years.

Students of dental hygiene at the University of Manitoba are also taught a number of extended duties in the field of orthodontics. These duties are legally permissible in Manitoba because of a clause in the Dental Association Act which allows for a certain amount of freedom in the duties delegated to a hygienist. This clause states that the "Board", meaning the Board of Directors of the Provincial Association, may pass by-laws "prescribing other specific dental duties of a minor nature that may be similarly delegated for performance by dental hygienists"(1). Manitoba is not the only province whose legislation contains such a phrase but it is fortunate in the interpretation of this phrase. The Board of Directors of the Province of Manitoba has shown a certain unwillingness to enumerate every duty that can be competently handled by a hygienist with training. They are generally in agreement with the aims and recommendations of the policy of the Canadian Dental Association concerning the expanded duties of auxiliary personnel. This policy states that the aim of the Association is "to increase the number of dental auxiliaries and expand the services which they are legally permitted to render." (2) It further outlines that "the services that these auxiliaries are qualified to render must be included in the prescribed teaching programs, and must be under the direct supervision of a qualified dentist." (3) Finally, it states that "the licensed dentist must retain full responsibility for the patient's welfare." (4) It is largely this interpretation which allows the University of Manitoba to carry on its experimental program in the field of orthodontics.

(1) The Dental Association Act, Clause (c) of Section 14, Chapter 62 of the Revised Statutes.

(2) Policy statement, Projection of Dental Services in Canada, Canadian Dental Association, June 1961 (Revised).

(3) Ibid (4) Ibid

Dental hygiene students at the University of Manitoba are trained to do the following orthodontic duties:

1. To take and compile all the diagnostic records necessary before orthodontic treatment can begin. This includes:
 - a) exposing lateral and posterior-anterior cephalometric radiographs
 - b) tracing the anatomical landmarks and measuring the angles necessary for a cephalometric analysis
 - c) taking black and white frontal and profile photographs
 - d) exposing a full-mouth survey of intra-oral radiographs
 - e) making impressions for study models which are poured in plaster and trimmed to orthodontic specifications.
2. Then as part of the actual orthodontic treatment they are trained to do the following:
 - a) select bands
 - b) mix cement
 - c) remove excess cement from around the edges of bands
 - d) clean loose bands before they are re-cemented
 - e) weld brackets and tubes to bands
 - f) heat treat arch wires
 - g) polish arch wires and bands
 - h) remove arch wires.

It is to be noted that these duties would be performed by the graduate hygienist in an orthodontic practice in addition to the traditional duties of the prophylaxis and topical fluoride. A thorough prophylaxis and topical fluoride must be done routinely on every patient before the bands are cemented to the teeth and after they are removed. The hygienist would also be responsible for diet instruction and analysis when indicated and patient education as it relates to toothbrushing, the use of elastics and cervical traction, and the care of retainers.

The orthodontic program being offered to the students in second year dental hygiene consists of six hours of lectures and six hours of laboratory in the first term and twelve hours of clinical experience in the second term. The lecture program includes material on growth and development, clinical orthodontics and diagnostic records. The laboratory sessions include instruction in diagnostic records, tracing and analysis of cephalometric radiographs and orthodontic technique.

The twelve clinical hours are spent in the Graduate Orthodontic Clinic where the dental hygiene students assist first and second year orthodontic graduate students. During this time they take all the necessary diagnostic records and assist them in every way a hygienist would if she were employed in an orthodontic practice.

The success of this program is difficult to evaluate at present. The program has been in operation only one year and as yet no graduate hygienist trained in this program has been employed in an orthodontic practice. However, notwithstanding this short history, the following conclusions can be made regarding this program:

1. Graduates of dental hygiene, although they do not become proficient in the various procedures in which they are instructed, do possess sufficient theoretical background and limited skills which enable them with experience to learn the procedures peculiar to an orthodontic practice.
2. It stimulates in dental hygiene students, an interest for an area of dentistry that can utilize the services of a hygienist to a great advantage.
3. And finally, extended duties in the area of orthodontics give variety and pleasure to the work of a hygienist. This is a consideration not to be taken lightly when one is considering the future role of the dental hygienist. It is important that the work of a hygienist be sufficiently interesting, challenging and varied to keep hygienists in the profession. Expanding the duties of a hygienist is one way of meeting this challenge.

THE NECESSITY OF A DENTAL HYGIENISTS' ASSOCIATION*

Mrs. J. Gardner

It is a distinct pleasure for me as President of the Canadian Dental Hygienists' Association, to be here to talk on the necessity of a dental hygienists' Association. As a way of introduction, let me give you a brief history of the CDHA.

Ontario had the first dental hygiene school in Canada and the graduates from the dental hygiene school at the University of Toronto organized as an Alumni Association. It was while working in this initial organization, that the need for a national hygienists' Association became apparent. The Alumni Association, with hygienists from Alberta and Nova Scotia provisionally adopted a constitution for the CDHA in 1963. The Ontario Hygienists' Alumni then became the Ontario Dental Hygienists' Association and with Associations from Alberta and Nova Scotia, they made up the charter constituents of the CDHA. Manitoba and British Columbia have since become constituents with the CDHA as well. Membership figures for the four years are as follows:

1963-'64	Active	82	Junior	12	1964-'65	Active	87	Junior	21
1965-'66	"	130	"	56	1966-'67	"	220	"	55
Associate 8 (4 in Sask.)									

We hope that our membership will continue to show a growth in good proportion to the number of new hygienists in Canada each year. At the present time we have slightly over half of the Canadian hygienists as members, 220 from a possible 422. But at less than 60% we find it difficult and ourselves at a disadvantage to accept the right to speak for all hygienists. If our membership fell below half, we would not be able to claim the right to do so. A goal of 75-80% should not be an unrealistic goal and we should not be satisfied with less. Yet no one joins any association for noble and lofty thoughts alone, and many people manage to keep very happy while avoiding membership in their professional associations. They avoid their responsibility by ignoring it, but the responsibility still remains. Let me now mention some reasons why I think there is a necessity for a dental hygienists' Association in Saskatchewan and your membership in it and the CDHA.

Unlike good champagne which takes 10 or more years to reach maturity - five years before the vines can even be harvested and another 5 to 6 years of aging the wine before it is ready to bottle and market, the CDHA in its short span of existence, has become the recognized body to speak for and represent hygienists in Canada by the British and American Dental Hygienists' Associations, the Canadian Dental Association, the American Dental Association and also the federal government. Our group, as the only organized body, has and will be asked to contribute its thoughts and ideas. This is one reason for the organization, and a vitally important one to all of us. We must have a strong representative dental hygienists' Association in the months and years to come. With the ever increasing demand to provide additional dental services, auxiliaries such as our own will be under great pressure to determine our future role in the changing picture. Will it be an expansion of our role, the expansion of other auxiliary's role, or the formation of another type auxiliary? The CDHA, the national organization, at the present time is the only effective body of hygienists that will have the opportunity to speak for Canadian hygienists. Not because we are necessarily the most knowledgeable, but because the demand is so great and the time to find an answer so short. We must come up with a workable solution. In the past, the CDHA has been asked for our views on the role of the hygienist. Now our aim to have direct representation has been recognized and either the Chairman of the Special Committee or myself will be our representative to the CDA Committee on Auxiliary Services.

* Presented at the Western Canada Dental Hygiene Convention, Regina, Saskatchewan. October 10, 1967.

While direct control of our profession remains with the dental profession and we do not have the burden of it, we must responsibly accept this chance to influence the direction in which we will move. The challenge has been given to us, our response must not come too little nor too late. We should no longer be willing to leave the future of dental hygiene only to those outside our own profession, those in academic isolation or those who might only be motivated by self-gain. However, to do this, to offer any suggestions or direction, we need information from all hygienists so that we can form an educated opinion, one truly representative.

Beginning with yourselves as individuals, I hope you will learn and know something of the past studies on expansion of our role, committee reports and recommendations made on this; become knowledgeable yourselves so we, your leaders, will know where the Canadian hygienists want to go. In keeping with this, the CDHA journal, "The Canadian Dental Hygienist, Summer '67 issue, published that part of the Hall commission pertaining to dental hygienists and other auxiliaries, and also the March 1966, CDA Auxiliary Services Committee Report. If you are not familiar with these and later on become so, discuss them among yourselves and with the dentists. A questionnaire will be going to all C.D.H.A. members asking them for their views on these matters. Our report as the CDHA to the CDA Auxiliary Committee will probably affect all of you, are you going to have a say in what it will be, or will you learn what was decided for you? Everyone who has an interest in dental hygiene must have an interest in the Association that represents hygienists.

The second reason I would like to mention as being important is the matter of dental hygiene education. It should be of interest to you that a sub-committee of the CDA Council on Education has been charged with dealing with guidelines in respect to dental hygiene training, including a study of the possible effects and applicability of degree programs in dental hygiene and a study of the possible effects and applicability of diploma courses in dental hygiene in post-secondary institutions other than universities. Here again an answer or an opinion should be formulated on our part. Our Education and Recruitment Committee through its constituent members will be asked to prepare itself to accept the responsibility for seeing that the Committee will know the members views on this. If we are asked, will we have the necessary information from You on dental hygiene education? Already the Ontario Dental Hygienists' Association has been asked by the University of Western Ontario to state their views on a degree course in dental hygiene at that University. This they did by the adoption of a resolution at their annual meeting. They have also been asked by the Provincial Government of Ontario to present a brief to a committee on the healing arts. They are to include in their brief, their views and recommendations on their present status; the relationship of themselves to others in dentistry; recommendations on regulations under the dental act of Ontario; their present education; and to also make recommendations on the expansion or reduction of their duties. While these two matters involve only the Ontario hygienists at the moment, can you honestly admit that it may not have some effect on all of us? In the foreseeable future, we may well be asked to do the same on another provincial level or even a national level. If you were asked here in Saskatchewan to present a brief including views on your present and future education, etc. would there be an organized, representative voice for hygienists? We must all be prepared to project our thinking to the dental profession, educators and governments.

This is one aspect of education, there is also the matter of continuing education programs for graduate hygienists. It is my personal hope that in the future, the CDHA by working among ourselves, with the CDA Council on Education and various schools of dental hygiene, can co-sponsor continuing education programs that will keep our members up-dated in knowledge and methods. These courses are invaluable in giving us a chance to exchange ideas and knowledge with others. As graduate hygienists, allowed to wear the cap and pin, we must accept the further responsibility of seeing that we do not remain static in the matter of education. It is necessary to maintain the present standard of dental hygiene and to improve our status; continuing education courses can be the answer. Even improvement does not always guarantee one ultimate success in life because you will find that there is also competition. While you are improving yourself, there are others also doing the same and perhaps doing a better job than you. Lately, I have heard the charge of "prima donnas" leveled at hygienists. I could accept this, if I were sure that the connotation meant was "A valued or valuable auxiliary on the dental team", because to remain as prima donna, one has to work hard

to maintain the position. Let us not give the dental profession or others a chance to level the second definition at us, "A person who takes adulation and privileged treatment as a right."

I mentioned just a few minutes ago the need to project our image to the dental profession, educators and governments. There is also a need to project it to the public as well, particularly the young students we would like to see enter the profession. There are still too many who do not know us, or the services we can and do perform. Do not be lulled into thinking that our small numbers and in consequence the great demand is necessarily the best position to be in. There must be a steady and a significant increase in our numbers. To help achieve this we, through our associations should be actively concerned with recruitment. The Education and Recruitment committee are at work to help revise the information pamphlet on dental hygiene, working towards the use of movies or slide programs on recruitment that would be available for use across the country. Many of us take advantage of our individual contacts with patients to interest others in dental hygiene, but let us not ignore other ways we can improve our recruitment program and our image.

As a start towards achieving good communications, the past-executive members of the CDHA edited and printed the Summer 1967 issue of the Canadian Dental Hygienist, which I'm sure most of you have seen. It is and will continue to be the means for us to exchange scientific news, constituent Association's projects and activities and news and report of the CDHA itself. Until now, the only means of national communications has been the executive newsletters. Too often these, since they were sent only to the executive and delegates to the CDHA Board of Directors did not fulfill the need for adequate communication with our widespread membership. The official journal is going to be our opportunity to further link Canadian hygienists into a strong worthwhile Association as well as projecting our image and views to the dental profession and other health organizations.

By now you may realize that I firmly believe all progress is made through organization. Let me illustrate. A visitor was amazed to find so many mentally affected persons walking around the grounds of a mental institution in apparent freedom and asked. "Aren't you afraid with all these insane people around? Did you ever stop to think what would happen if they got organized." The supervisor smiled and answered, "If they knew how to organize, they wouldn't be here." I'm not here to suggest that you are crazy and this is why you are not organized. I realize that numbers and circumstances may not have allowed organization, but perhaps now the time is here. I believe that if you become a constituent Association and part of the CDHA, there is much you can do for the Association and our profession.

Let me assure you that the fellowship and friendship that you will find while being a part of the organizations are very tangible and worthwhile benefits. It is much like an education, hard to explain to those who do not have it, just what the fulfillment is. The CDHA hopes you will discover this for yourselves. We need more members to take an active part on our various committees and projects. Some of you may feel you are too green and could not do a good job. Let me put your mind at ease, being green helps. We all know that hay and fodder lose much of their vitamin content when they lose their green color. If you want to help our Association make hay, don't worry about being green, it helps. Also there is a saying you get out of something, exactly what you put in it. Like the woman who bought a book on reducing for \$3.00. After two weeks, she discovered all she had lost was her \$3.00. So it is with a dental hygienists' Association. You will get out of it what you put in - the knowledge that belonging to an Association and taking part in the work of it contributes to its strength and in this case the strength of the dental hygiene profession. This would be your benefit in the end.

Let me give you the Commandments of a dental hygienists Association which I have borrowed and changed to fit from the Eleven Commandments of a Good Practice.

A member
is the most important person in any association.

A member
is not dependent on us, we are dependent on her.

A member
does not interrupt our work, she is the purpose of it.

A member
does us a favor when she comes to a meeting.

A member
is not a cold statistic, she is a flesh and blood human with thoughts and feelings.

A member
is not someone to argue with, but to work with towards a common goal.

A member
makes it possible to carry out our aims and projects by payment of dues.

A MEMBER
is the life-blood of this and every association.

In the past months, I have read much in an endeavor to better express my thoughts to you. The various Journals of many Associations have contained articles that show we have and have had many common problems. Membership seems to be one; how to motivate to join and participate. It is my hope that I have been successful in doing so.

I would like to repeat. It is our goal to compete, to keep current and even ahead of the changes that will be coming. The change and rapid advancement of dentistry to provide services is demanding a complete rearrangement and organization of dental auxiliaries. This has been pointed up by many articles, pilot studies and the fact that this is one of the main goals of the Canadian Dental Association's President this year. These changes will undoubtedly place a greater responsibility on the shoulders of the dental hygienists. We must be aware of what the changes will be and make known our views on this and also on present and future education of hygienists. To accept the responsibility of doing so, of having a say, we must have a strong representative Association provincially and nationally.

C. D. H. A. CONVENTION, 1968

Where will you be June 26 to 29, 1968?

The Canadian Dental Hygienists' Association Convention in Vancouver, of course! But do not plan to get much rest! Our activities will keep you hopping from scientific sessions to wine tasting parties to business meetings to luncheons to table clinics and to chinese dinners. You'll be able to rubberneck like any tourist in North America's largest Westcoast seaport. Maybe even take in the beaches and shopping.

Hotel space has been held at the Hotel Vancouver, the convention headquarters. Registration forms go out April 1st. Accommodation must be booked by May 30th so... **BOOK OUT YOUR HOLIDAY TIME NOW.**

Would you like to present a table clinic?

Contact your convention chairman... Mrs. Terry Kline
1136 West 40th Ave.
Vancouver 13, B.C.

GUESS WHAT WE'RE DOING?

Ontario - Dr. Marjorie Jackson, Director of Dental Hygiene at the University of Toronto reports that the school will be sponsoring a "Student's Night" in November. The object of this informal social gathering is to give the students and staff a chance to get acquainted 'out of school'. Following a presentation by a graduate on her work as a Hygienist in an Orthodontic practice, there will be a social hour and the staff expects to know the second year students better over a cup of coffee. If this is successful this year, plans will be made to repeat the evening with speakers from small towns or other specialists' offices.

Manitoba - Has set up a placement service to help both dentists who want to employ a hygienist and girls who want to move to Manitoba or who wish to change employers. We hope that this service, which is being run on a voluntary basis, will prove helpful to members of the profession. Inquiries may be directed to:

Miss Lois Blackwood
Dental Hygiene Placement Service
308 Kennedy Street
Winnipeg, Manitoba.

Nova Scotia - One hygienist here has devised 'report cards' for her pedodontic patients. Grades are given on dental health, brushing, etc. She has found this very effective in motivating patients.

The Nova Scotia Dental Hygienist's Association recently received a set of career slides from the ADHA with the hope that the members would feel better equipped to present dental health lectures. The slides are being used constantly, which would indicate that they are indeed filling a need. Since this time, the NSDHA has begun to make their own slides, which have also been used by all the members.

The Dental Health Committee of the NSDHA is preparing a dental health education material index. This will take the form of a list which will be revised periodically and will contain all available dental health education material, a brief description of its content and its source.

The NSDHA is again looking forward to this year's National Health Week, when they sponsor, with the help of the local dental association, a poster contest. Local radio and T.V. stations are helping out with spot announcements, school art classes feature 'poster day' and the children participated with enthusiasm.

BULLETIN

The College of Dental Surgeons of British Columbia has decided that dental hygienists wishing to practice in that province will not be required to write examinations before a license is issued to them. This is, at present, in effect for a limited time of two years.

DENTAL HYGIENE POSITIONS

Dental Hygienist

Urgently required in well established group practice in Vancouver suburb. Private operatory supplied in modern air conditioned building. Patients accustomed to hygienist services over a five year period. Excellent salary and working conditions.

North Vancouver Dental Group
124 E. 15th Street
North Vancouver, B.C.

Wanted

Dental Hygienist for Vancouver suburban office. Salary or commission depending on experience. Apply:

Dr. O.F. Wright
330 - 5665 Cambie Street
Vancouver 15, B.C.

Half-time Position in Dental Hygiene

A half-time position is available at the Winnipeg Children's Hospital to provide preventive dental services for children and adolescents. Duties will include hospital ward rounds and participation in special clinics for handicapped children. The stipend is \$2400 per year.

Please write to:

Dr. C.R. Castaldi
Faculty of Dentistry
Head, Pedodontic Section
University of Manitoba
780 Bannatyne Ave.
Winnipeg 3, Man.

Dental Hygienist Wanted

Clinic includes four dentists and one hygienist. Starting salary \$600.00 a month. Clinic located just twenty-five miles out of Vancouver. Apply stating age, experience, and qualifications to:

White Rock Dental Clinic
1538 Foster Street
White Rock, B.C.

Dental Hygienist Wanted

Three dentists in Vancouver, B.C. require hygienist. Offices located in 3 block radius. Good salary. For further information contact:

Dr. David Stanger, 2525 Pine Street, Vancouver 9, B.C.

Wanted

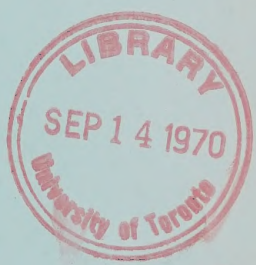
Dental Hygienist to serve three Dentists, five days per week on an alternate basis. Cavitron. Present Hygienist highly satisfied but getting married. Replies to Dr. A.J.S. Prothero, 306 - 4900 Kingsway, Burnaby 1, B.C.

Dent



THE CANADIAN
DENTAL HYGIENIST

SPRING
1968



pellet

THE CANADIAN DENTAL HYGIENIST

OFFICIAL PUBLICATION OF
THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION

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TABLE OF CONTENTS:

	Page
President's Message	4
Editorial	6
C.D.H.A. 5th Annual Convention	8
The Preventive Dental Program in Saskatchewan	10
Dental Health Week Activities	13
Correlating Dental Health Education with Classroom Instruction	15
British Columbia Dental Workshop	18
C.H.A. Auxiliaries Services Commission Report	22
Nutritional Counseling as an Approach to Caries Prevention	24
C.D.H.A. Policy Statement - Fluoridation	27
Official Opening of the J. B. MacDonald Building	27
Abstracts	28
Book Reviews	29
Positions Available	31

INDEX TO ADVERTISERS

	Page
Dentsply Canada, Ltd.	5
Warner-Chilcott Laboratories Co. Limited	3 & 7

Clinical evidence shows . . .

Steri/sol with Hexetidine prevents acid formation in dental plaque for up to 14 hours

Steri/sol is the *only* oral antiseptic containing hexetidine, a highly effective non-antibiotic anti-bacterial agent.

Clinical Tests show that "hexetidine is absorbed onto dental plaque . . . (and) effectively prevents the formation of acid for a period of 10 to 14 hours".*

These results indicate that routine use of Steri/sol with hexetidine can be a valuable adjunct to consistent and correct brushing, particularly in those cases where maintaining oral hygiene is a major problem.

*"The effect of Hexetidine Dentifrice and Mouthwash in the Prevention of Acid Formation in the Dental Plaque" . . . Presented at the Hexahydropyrimidine Symposium at Northwestern University, October 23rd 1958 by Leonard S. Fosdick Ph.D. Copies available on request.



Composition: Hexetidine 0.1%
Alcohol 9.0%
Directions: Use full strength, hold in mouth, swish and gargle for 30 seconds.
Side Effects: None reported
Precautions & Contraindications: None known
Full information available on request.

Available from pharmacies only.



WARNER-CHILCOTT
LABORATORIES CO. LIMITED
TORONTO CANADA

MEMBER

PMAC

PRESIDENT'S MESSAGE

Mrs. J. Gardner

"I fear that too often we limit our vision to what a single organization can or might do. In doing so we become so involved, so shortsighted, that we fail to take into account the effect of actions by one organization on other groups in the community." R.H. Boyes, President of Federated Cooperatives.

As hygienists in private practice or in public health, our actions in the performance of preventive services or in giving patient education are specifically planned to achieve a long term effect on the individual patient or the community as a whole - BETTER DENTAL HEALTH. The results and effects of our actions can readily be taken into account. It is not always so easy to see the effect of an Association.

In the past months I have read much in various dental journals, met with members of the dental profession and hygienists, been exposed to old and new concepts and viewpoints. The grand total of all this gain in information has led to some bewilderment. But from the bewilderment has come the realization that the pace and direction of dentistry is moving and changing rapidly to meet the requirements of the changing world. This rapidity of change has been emphasized as recently as March 19th when Prime Minister Lester Pearson stated during a TV interview that the world has moved more in the last 50 years than in the last 2500 years. None of us can any longer consider that the changes will not also affect dental hygiene. It will take all the efforts of hygienists as a group to keep apace with the dental profession and to work with them for the solution of problems. It is going to continue to require a dynamic and farseeing organization of keenly interested members to bring the profession of dental hygiene to its greatest ultimate potential.

As a base to work from toward this achievement, our Association is now completing its fifth year. The organ of communication, the journal - "The Canadian Dental Hygienist" has been created and well received. Groundwork and policies have been set down for the Association, its executive and committees. The pulse of the young organization is beginning to beat more strongly. As hygienists across Canada are being stimulated into thought of their future, and these thoughts become crystallized into action, it is obvious that dental hygiene will be moving too. As the direction of our movement is more precisely determined, then its effect will be noted by others. Let us work together to insure that our Association's visions become worthwhile long term actions for the benefit of others as well as ourselves.



Nicest thing my Doctor ever did for me.

The Dentsply-Cavitron saves me so much hard work. It *brushes* calculus away gently, softly, quickly. Even the heaviest deposits are dislodged without effort. And my patients are much more relaxed during the treatment, and experience less discomfort afterwards.

Why not ask your Doctor to arrange a Cavitron demonstration for you? Believe me, it will be good for you, good for your Doctor and good for your patients.

Dentsply® Cavitron® "660"
ULTRASONIC DENTAL UNIT

Dentsply Canada, Ltd. Toronto 2-B, Ontario

This unit is covered by one or more of the following U.S. Patent Nos: RE 25,033, 2,580,716, 2,990,616, 3,075,288, 3,076,904, 3,086,288 and 3,213,537, and corresponding foreign patents.

EDITORIAL

"A person entitled to practice dental hygiene may do so under the direct control and supervision of a licenced dentist." In all the provinces of Canada the law provides that a hygienist work in close proximity with a dentist, and under his supervision. In many provinces it is further stipulated that the hygienist be under his direct control at all times.

Exactly what does this mean? There are as many ways to interpret this bit of legislature as there are dental clinics and practitioners. Direct supervision in a private dental office is usually simple--the dentist and hygienist must both be there at the same time. In a clinic, where there may be more dentists than hygienists, supervision becomes even more basic. It is only a matter of having at least one practitioner in the clinic while the hygienist has a patient in her chair. Institutions and government agencies often employ hygienists who work in schools and hospitals when there is no dentist present. To have direct supervision of these girls, a dentist would have to be on staff to make the rounds with them.

In essence, the law reads as it does for the protection of all concerned. There may be a dentist who would prefer to spend the afternoon on the golf course while his hygienist sees some of his patients. He may expect her to carry out some procedures for which she is not qualified or competent. So the law stands as it does to protect the hygienist against law-suits by a patient under these circumstances and to protect the patient against accidents. If a patient should have an epileptic seizure, a coronary or any other serious condition, a dentist trained in emergency procedures would be present. When the dentist is there, there is a great addition to the patient's peace of mind and the hygienist's composure.

There are many people who feel that the direct supervision clause is not necessary. If the dentist assumes responsibility for his hygienist's actions, and this he is compelled to do, there should be no reason why he must be present at all times. The dentist who employs a hygienist does so at premium salary, and does not wish to pay unproductive personnel during his absence.

What could happen if a hygienist were to be reported for malpractice because she was working without supervision? In most provinces at least two things:

- 1) her dentist-employer would bear the brunt of the attack, perhaps he would be fined by the provincial dental association.
- 2) the hygienist, even though she is working at her employer's insistence, could have her licence revoked.

As far as I know, these have yet to happen, but they are very real possibilities.

There is no one solution to this problem, but a small choice of answers include:

- 1) the law of the province could be changed. However, once a practice act is opened the whole act may be reviewed, and this can be a lengthy and perhaps undesirable procedure.
- 2) adhere strictly to the law as it stands. This would be no great hardship, even if it meant the occasional 'office-girl' day for the hygienist.

In order for the hygienists to take a stand on this issue, the support of the local or provincial association is imperative. A stand must be taken, a procedure must be adopted and it must not be flexible. The decision to work or not to work when unsupervised is not really one for the individual hygienist, or for her dentist-employer; it is one for the dental associations and the legislature. Their decision would be final and their authority would be recognized. The law must be obeyed.

announcing a new treatment for the chronically unhygienic mouth:

The Steri/sol Healthy Mouth Kit—created especially for those patients who have a major problem maintaining oral hygiene. Steri/sol is the only oral antiseptic containing hexetidine, the anti-bacterial agent that effectively prevents the formation of acid in dental plaque for up to 14 hours. For this reason, routine use of Steri/sol can be a valuable adjunct to consistent and correct brushing.

To help solve the problem of the chronically unhygienic mouth, we have developed the Healthy Mouth Kit, containing a sample of Steri/sol, and a booklet describing the techniques of correct oral hygiene. We are sure you will find the Kit valuable in maintaining your patients' oral health.

If you would like a sample of the Steri/sol Healthy Mouth Kit, write to: Warner-Chilcott Laboratories, 2200 Eglinton Avenue East, Scarborough, Ontario.



Steri/sol

Composition: Hexetidine 0.1% Alcohol 9.0%

Directions: Use full strength, hold in mouth, swish and gargle for 30 seconds.

Side effects: None reported.

Precautions and contraindications: None known.
Full information available on request.

WARNER-CHILCOTT
LABORATORIES CO. LIMITED
TORONTO CANADA

C.D.H.A. 5th ANNUAL CONVENTION

Mrs. Jo Gardner, President of the C.D.H.A. invites dental hygienists from all parts of Canada to the 5th annual convention in Vancouver, June 26 to 29, 1968. Registration forms have been sent to all C.D.H.A. members for early registration and hotel reservation. If you misplace your original registration form, you may use the one reproduced in the journal. Further information from Mrs. Terry Kline, 1136 W. 40th Ave., Vancouver 13, B.C.



Vancouver is waiting to greet you in June
With the softest of air and the silveriest of moon
The weatherman's bribed, the program is set
The western hostesses have planned fun that is jet.

A program to stimulate, challenge and probe
Our professional problems from all round the globe
All the info's enclosed in this pre-convention kit
So register early — endorse and return it.

You'll save some cash by doing it now
And save the committee that "furrowed brow"
Mauve shifts will identify your B.C. guides
This convention to you we present with pride.

REGISTRATION FORM
VANCOUVER, B. C.

CANADIAN DENTAL HYGIENISTS' ASSOCIATION
CONVENTION
JUNE 26 - 29

FEES	Pre-Reg. (by May 25)		Post-Reg.
CDHA member	\$20.00		\$23.00
Non CDHA member	22.00		25.00
Students			
Junior Member	\$ 4.00 per each meal attended		
American Visitor			
Husband or escort attending			
Chinatown evening	\$ 4.00		

REGISTRATION FEE INCLUDES ALL SCHEDULED SOCIAL AND SCIENTIFIC SESSIONS

Miss, Mrs. CDHA Member? Yes No
Address
.....

Total fee enclosed \$ _____ +15c exchange Did you include \$4 for husband or escort? Yes No

Payable to: Canadian Dental Hygienists, Association

MAIL TO: Mrs. Michael Balanko, 2158 West 34th Avenue, Vancouver 13, B. C.

Hotel reservation deadline is May 25th. After this date we cannot guarantee you a room. SO RESERVE NOW!

WEDNESDAY, JUNE 26

9:00 a.m. — 4:00 p.m.

C.D.H.A. Board of Directors Annual Session
open to general membership if you wish to attend
(President's Suite)

7:00 p.m. — 10:00 p.m.

REGISTRATION and HOSPITALITY
(President's Suite)

THURSDAY, JUNE 27

8:00 a.m.

REGISTRATION (Social Suite Foyer)

9:00 a.m. — 10:15 a.m.

ESSAY — Columbia Room
Dr. Gerald D. Stibbs, Seattle, Washington
"The Whole Profession"

10:30 a.m. — 12:00 noon

PANEL DISCUSSION — Social Suite East
"Your Profession of Dental Hygiene"

- * Dr. W. Ross Upton, Registrar
College of Dental Surgeons of B.C.
- * Dr. J. F. Reid, Chairman, Auxiliary Services
Committee, B.C. Dental Association
- * Mrs. Bonnie Craig, Secretary, Canadian
Dental Hygienists' Association
- * Miss Margaret Robinson, Supervisor
Department of Dental Hygiene, University of
British Columbia

12:00 — 2:00 p.m.

LUNCHEON — Social Suite East
Guest Speaker, Dr. Dennis Shalman, Psychologist

2:30 p.m. — 3:30 p.m.

ESSAY — Columbia Room
Dr. Saul S. Schluger, Seattle, Washington
"Maintenance of Periodontal Therapy — After Care"
(The Hygienist and her Employer)

5:00 p.m. — 7:00 p.m.

WINE and CHEESE TASTING PARTY
(President's Suite)

FRIDAY, JUNE 28

9:00 a.m. — 11:15 a.m.

TABLE CLINICS — British Room

- * "A Day in Public Health" — Mrs. Evelyn Peglar,
R.D.H., Nova Scotia Dental Hygienists'
Association
- * "Orthodontic Techniques for the Dental
Hygienist" — Miss Jill Downton, R.D.H. and Miss
Louise Pollard, R.D.H., Manitoba Dental
Hygienists' Association
- * "The Ontario Hygienist" — Miss Leslie Harris,
R.D.H.; Miss Joan Hubbert, R.D.H.; Miss Ninfa
Johnson, R.D.H.; and Miss Pat Brett, R.D.H.,
Ontario Dental Hygienists' Association
- * "Doctor, Are You Helping to Recruit Hygienists?"
Miss Ruth Carter, R.D.H., British Columbia
Dental Hygienists' Association

10:00 a.m. — 11:00 a.m.

ESSAY — Social Suite East
Dr. C. R. Castaldi, Winnipeg, Manitoba
"The Oral Health of Children in the Eighteen Month
to Four Years Age Group"

12:00 — 12:30 p.m.

NO HOST COCKTAIL PARTY — Social Suite West

12:30 p.m. — 2:00 p.m.

LUNCHEON — Social Suite West
Fun Fashions for the Office presented by
The Rose Uniform Shop

2:00 p.m. — 4:00 p.m.

ANNUAL GENERAL MEETING AND
INSTALLATION OF OFFICERS, C.D.H.A.
(Social Suite East)

6:00 p.m. — 10:00 p.m.

EVENING IN CHINATOWN

7:00 p.m.

CHINESE BANQUET
Lotus Gardens — Lotus Hotel

SATURDAY, JUNE 29

9:00 a.m. — 11:15 a.m.

TABLE CLINICS — British Room

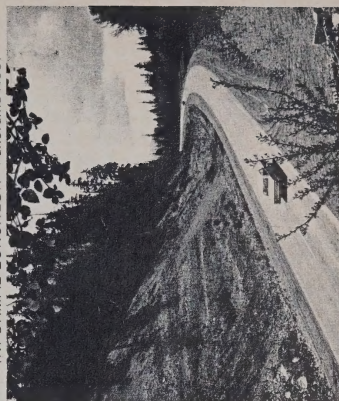
- * "A Dental Hygienist in Your Practice?"
Miss Ruth Carter, R.D.H., and Miss Joan
Sanders, R.D.H., British Columbia Dental
Hygienists' Association
- * "Keeping Smiles for the Future" — Dr. Alan
S. Gray, Miss Irene Jordan, R.D.H., and Miss
Donna Gunther, R.D.H., Okanagan Dental
Health Team
- * "The Hidden Truth" — Miss Sheila Hoople, R.D.H.,
University of Washington, Seattle, Washington
- * "Oral Hygiene and the Handicapped" Alberta
Dental Hygienists' Association, Miss A. MacIntosh,
R.D.H., and Mrs. M. Wilson, R.D.H.

10:30 a.m. — 12:00 noon

ESSAY — Social Suite East
Mrs. Lona Hulbush, First Vice-president, American
Dental Hygienists' Association,
"Dental Hygiene and the Changing Times"

12:30 p.m. — 2:00 p.m.

INFORMAL LUNCHEON - Panorama Roof



*Girls, please wear your name badges at all times
Commercial exhibits will be open throughout the convention*

THE PREVENTIVE DENTAL PROGRAM IN SASKATCHEWAN

Shirley A. Johnston, R.D.H.
Dental Health Division
Yorkton-Melville Health Region
Yorkton, Saskatchewan

The following program now being implemented was designed by Dr. A.L. Lizaire, Dental Public Health Officer, Department of Public Health, Province of Saskatchewan. Although the foremost objective of this program is to increase the dental health standard of our population through dental health education, we can more precisely say it has four main objectives:¹

- (a) To determine the distribution of dental diseases prevalence within given age groups.
- (b) To prevent, within these age groups, those still immune from becoming affected.
- (c) To reduce the incidence among those already affected.
- (d) To detect and possibly remedy the most serious consequences.

In order to evaluate the program a control population from the provincial survey will be compared every five years with those among whom the program has been implemented.

Before the program begins in the School Unit arrangements are made with the Superintendent and school principals involved.

This program is divided into three phases.

PHASE ONE - consists of a detailed dental survey by the dental hygienists and includes:

(a) All school children from six (or school beginners age) to twelve years of age inclusive, up to September 30th of each year, and belonging to a school unit or Superintendency.

The present program takes place in the Kamsack (Yorkton-Melville Health Region) and Cupar (Regina Rural Health Region) school units only.

(b) The children are examined as to their d.e.f., D.M.F., lower first permanent molars, lower anterior papillae, oral hygiene, malocclusion, systemic fluoride, prophylaxis, topical fluoride, according to the Canadian Dental Index. For this, Dental Examination Card No. 1 (DEC #1) is used. If any dental treatment is required, the child is given a dental referral card which he or she presents to the family dentist. Upon completion of treatment, the dentist signs the card, which is returned to us and becomes part of the child's record.

(c) From the DEC #1, a computer rating is established for each child. Depending on the caries attack rate, a child will be in the resistant, low, high or rampant decay group.

(d) Following establishment of the computer ratings, a full statistical report is made for every school, according to age groups, using the Dental Public Health Statistical Report Form. Upon completion of all schools within the Unit, another report is made encompassing the total unit.

¹ Reported by Dr. A.L. Lizaire, D.P.H.O. in Canadian Nutrition Notes, Vol. 23, No. 6, June-July 1967.

PHASE TWO - only those children found to have a high and rampant computer rating participate in this phase. Interview appointments for parents of those children are scheduled at the schools. The length of the interview varies according to the number of children in the family who are eligible to participate. Usually one hour per child is sufficient with one-half hour for each additional sibling. With the parents permission these children are subjected to a more extensive examination including:

- (a) Medical history
- (b) Nutritional history - prenatal
 infancy
 early childhood
- (c) Communities lived in
- (d) Dental history
- (e) Oral hygiene
- (f) Present oral health status and supporting or laboratory data obtained from:

1. Swab test (as described by Grainger, Jarrett and Honey) to evaluate, by the pH, the activity of the oral bacterial flora. The Metrohm portable electric pH metre E280 A with a combination micro-electrode is used.

2. Blood test (Hb) using the AO Spencer Hb metre, and the Hb Normality Range by sex and age, as established by the Federal Laboratory of Standards, for the detection of anemia, and particularly of nutritional anemia, especially in view of the large number of Indians and Metis in the area in which we work.

3. Urinalysis using the Labstix Reagent Strip, for determination of proteinuria, glycosuria, ketonuria, hematuria and urinary pH. Following 2) and 3) above - if any abnormal symptoms are found, the child is given a medical referral card. Following completion of treatment by the family physician, the card is signed and returned to us to become part of the child's record.

4. Qualitative dietary analysis - in this booklet the parents accurately record the child's diet for seven consecutive days. Upon completion and return of the booklet, it is forwarded to the nutritionist for evaluation and recommendations. Not only must the diet be balanced, it must be specifically balanced to eliminate dental diseases.

Following recommendations in writing by the nutritionist, the booklet and recommendations are then brought to the hygienist and discussed. From time to time the nutritionist chooses to further discuss some cases with the hygienist responsible for the patient, or the hygienist herself may call on the nutritionist whenever she feels that she needs to do so, for more detailed information regarding a particular case, etc.

As a follow-up evaluation, the patient's saliva pH is taken, at periodic intervals showing the effect of the anticariogenic balanced diet on the flora of the mouth; the acid formation must decrease in proportion to the acid forming organisms population. This is the Snyder test as improved and standardized by Dr. Grainger, Dr. Jarrett and Dr. Honey². It is then possible to tell whether the prescribed diets have in fact been followed, measuring the performance of the patient and judging the duration and severity of the prescribed anticariogenic diet.

All information pertaining to Phase Two is recorded on the Preventive Case History Form.

At this point we realize the potentiality of nutrition, as well as dental and general health education of such a program and the tremendous impact this will have on the dental as well as the general health status of our younger generation.

² Dr. Grainger of the Faculty of Dentistry of the University of Toronto, Dr. M. Jarrett, Dental Health Director, Wellington-Dufferin, Halton, and Wentworth County Health Units, and Dr. S.L. Honey, Dental Health Director, Welland and District Health Unit.

PHASE THREE - consists of prophylaxis and topical application of acidulated phosphate fluoride for the entire group of children who participated in Phase One. This is done on an appointment basis, during the summer months because of the possibility of getting help from the Faculties of Dentistry and Schools of Dental Hygiene. Agreements have been made with these Institutions as well as with the College of Dental Surgeons of Saskatchewan.

Once this data has been collected it will be used for immediate educational and remedial purposes, as well as for epidemiological studies and statistical correlations.

In this perspective it was imperative the forms to be used in this program would be compatible with our objectives, producing the very kind of information needed; and also that these forms would be drafted in such a way that the electronic equipment, the computers, which are eventually to be used in our data processing will be able to get from them the information obtained from the patients. Furthermore, to avoid possibility of errors involved in the transcription of the codified data, each item recorded is automatically codified, and does not have to be transcribed for the IBM card puncher.

For all this and much more, we are profoundly indebted and grateful to the Nutrition and the Research Planning Divisions. The craftsmanship of these forms is due to the Health Education Division and the Reproduction Centre of our Department. To them also, we are indebted and grateful.

In this description I have tried to give an idea of the scope of our Preventive Dental Program, and of the principles and techniques upon which it has been built.

A. D. A. CONFERENCE ON JOURNALISM

Mrs. Patricia Kerr

The editorial and advertising content of a professional publication should encourage health and promote dentistry. This was one of the points made by Dr. D. W. Edwards, chairman of the Council on Journalism, at a two day conference held in Chicago on April 22 and 23, 1968. The meeting was well attended by over ninety dental editors from the U.S. A. The two Canadian journals represented were the C.D.A. journal by Dr. Frank Compton, and our C.D.H.A. journal by myself.

The purpose of the meeting, which took the form of workshops, was to further the dental editor's awareness of this responsibility to his association and to assist him in producing an interesting and attractive journal. Speakers at the one formal meeting covered the Internal Revenue and Publications Advertising Tax, Postal laws governing periodicals, reports of the American Association of Dental Editors, and a general topic 'the Editor's Desk'.

The two workshops to which I had requested assignment were:

1. Orientation: for the newly appointed editor. This workshop gave ideas on advertising policies, reprint policies, etc. Some of the topics that were covered included the responsibilities of the editor, his place in the dental organization, and the purpose of the dental publication.
2. Advertising Codes: a guide to formulating a code or revising an existing one. All types of advertising were discussed, as well as the guides for determining the acceptability of certain ads. Protection of the public should be a prime consideration in selecting advertising, said Mr. J. Hollister, director of the A.D.A. Dept. of Sales and Advertising. This workshop was very helpful to me in setting up a proposed advertising code for our journal.

This was a most worthwhile and rewarding conference.

DENTAL HEALTH WEEK ACTIVITIES;

ALBERTA AND BRITISH COLUMBIA

ALBERTA

Dental Hygienists in the two major cities of Alberta, Calgary and Edmonton, were hard at work during the week of March 11th to 15th doing their bit to promote dental health week in those cities. It was the first time a venture of this sort has been undertaken in the province but it is hoped it will be an annual event.

For their part, the Calgary Dental Health Week Committee utilized the public media to reach the people with dental health messages of various types, for example, radio and T.V. spot announcements, and a T.V. interview was planned. Various sign boards in the city, for example, Safeway, A & W, and a local drug-store chain displayed dental slogans during the week, all complimentary to the Dental Hygienists Association. The big project of the week was the poster contest held among Junior High School students in Calgary and the Mount View Health Unit. The T. Eaton Company donated a large display window for the purpose of displaying contest entries. From all reports, the contest generated a lot of enthusiasm and some very promising art work.

In Edmonton, on the Tuesday of Dental Health Week, twenty-five dental hygienists and nine senior students of the School of Dental Hygiene divided up into fourteen teams to visit various medical and welfare institutions in the city for a dental health education blitz, and distribution of tooth brush kits. Some of the places visited were the Charles Camsell Hospital for Indian and Eskimo children, the Winnifred Stewart School for retarded children, the Diagnostic and Treatment Centre, Woodside and Pineview homes for unwed mothers, the Alberta Institute for Girls, and others. Two of the talks, those at the School for the Deaf, and the Marydale Treatment Centre for emotionally disturbed children, were given just to staff members.

As in Calgary, the various media were utilized, involving radio and T.V. spot announcements, and local dental hygienists appeared on two T.V. programs. One program consisted of a half-hour visit to the Charles Camsell Hospital, showing the dental hygiene team at work presenting their puppet show to interested onlookers, and concluding with an interview. Two articles appeared during the week in the local newspaper; one covering the activities at the Charles Camsell Hospital.

BRITISH COLUMBIA

A report on media coverage secured as a result of public relations services rendered the B.C. Dental Hygienists Association for Children's Dental Health Week - February 4 - 10.

A. TELEVISION

All four Canadian-content television stations serving the Lower Mainland devoted coverage to the Week, in the following manner.

1. A 40-minute "live" interview of Miss Marcy Miller aired on the Jean Cannem Show on CHAN-TV (Channel 8, Vancouver).
2. Prime time evening news coverage of Dental Hygienists' visit with milk and apples to Children's Hospital was carried by film on CBUT (Channel 2, Vancouver), CHAN-TV (Channel 8, Vancouver), CHEK (Channel 6, Victoria). Also showed Hygienists demonstrating good brushing methods.

3. A five minute "live" interview of Miss Marcy Miller aired on the Elain Horne Show via KVOS-TV (Channel 12, Bellingham USA). The appearance resulted in an invitation to Miss Miller to return for three additional five-minute taped interviews for subsequent viewing.

B. RADIO

1. All six Vancouver radio stations carried the four 30-second taped messages, produced by the Agency, though assessment of value is difficult because of the inherent problem of monitoring. The tapes were heard on 6 stations.

Until confirming reports are received by letter from each station, it is not known at present the incidence of usage of the tapes. However, one particular station (CJOR) carried the tapes five and six times per day throughout the week.

In addition, of the six other stations which received the taped messages and honorarium cheque, none has returned its cheque - thus it can safely be assumed at present that all six used tapes. These stations were: three Victoria stations; one Prince George; one Trail; one Kelowna. Victoria used the messages on 14 occasions.

2. A three-hour open line interview on all facets of children's dental care of Dr. Spencer Gallagher and Miss Marcy Miller on the Jim Macdonald/Bob Bye Show on CKWX radio.
3. A prime time morning interview of Miss Marian Alexander and Miss Marcy Miller of approximately seven minutes on the Monty MacFarlane Show via CJOR radio.
4. A prime time morning interview of Miss Marian Alexander and Miss Susan Lighthall of approximately six minutes on the Bob Hutton Show via CKNW radio.

C. READ-O-GRAPH BOARDS

Children's Dental Health Week messages are known to have been carried on read-o-graph boards in Vancouver and on Vancouver Island.

D. NEWSPAPERS

1. A four-column photo of Miss Marcy Miller and a patient at Children's Hospital appeared in the Vancouver Sun.
2. A photo of Miss Marcy Miller and appropriate dental props distributed by the Agency appeared in sixteen papers throughout British Columbia.

CORRELATING THE DENTAL HEALTH EDUCATION PROGRAM WITH CLASS-ROOM INSTRUCTION GIVEN BY THE TEACHER IN THE SCHOOL*

Mrs. Roberta MacConnell, B.A., R.D.H.

While the title of this paper may indicate drastic changes in the dental hygiene program in the school, be assured that it is simply an extension and enrichment of the educational aspect of our program. The process of enrichment can best be demonstrated by giving a detailed explanation concerning the procedure of conducting a clinic in the school.

The first school contact is a conference with the principal, in which the educational and clinical aspects of the program are explained. Special emphasis is placed on education and permission is asked to conduct projects with each class. The consent of the principal is a necessity, since he must know what is going on in the school. As such projects can and do interrupt regular classroom schedule, it is prudent to have the blessing of the administration before embarking on them.

Having gained the sanction of the principal, each teacher is approached before the clinical work is begun with her class. This individual chat is preferred to a group teacher conference because of the more personal contact. During this talk the nature of the hygienist program is briefly explained. Permission is asked to meet with her class at a time convenient to her. It is also pointed out that while the class lists have been prepared in alphabetical order, she may send the children to the clinic at her discretion. The only request the hygienist should make is to have the most extravert children attend the clinic first, since this gives the shy child an opportunity to see that 'it doesn't hurt'. Before leaving, inquiries are made concerning any emotional problems in the class. Such knowledge can facilitate work in the clinic.

Following this conference with the teacher, the class is approached for an introductory talk in which a blow by blow description of the clinic procedure is given. This description should vary according to the age of the children, but at all times should be in a language the children understand. The introductory talk is advantageous, since it gives the hygienist and children an opportunity to become acquainted. The children also know what to expect before coming to the clinic. A previously unknown situation becomes understandable and therefore less fearful. This saves a multitude of questions and problems later.

After the talk, the actual clinic work is begun. Midway through the class, another conference is held with the teacher. Arrangements are made for a second class talk in which some aspect of dental health will be discussed. To round out this talk, it is hoped to initiate a class project. Since the teacher's assistance is essential, it is necessary to find out if she is willing to carry out such a project.

At this point it seems advisable to explain the term "project". It is some form of activity in art, English or music which will make the dental health lesson more meaningful. These projects will vary with the age and capabilities of the children. There should be a different project with each class. Since time is at a premium, the teacher and hygienist should try to work out a means of correlating this project with regular class work. Correlation is the capacity to draw in as many subjects as possible in a project.

The following projects have been tried with varying degrees of success.

* Presented at Nova Scotia Public Health Staff Conference, Kentville, N.S.; November 1967.

1. ART

- A. Individual Posters: are suitable for Grades Four and Five. Each child makes a small poster on manilla paper, illustrating some point of dental health. The child learns the essentials of poster making. (a) It must be interesting and eye-catching; (b) it must contain one concept and the printing must be legible. Each child can create in his own style. It also has an additional advantage because it can be completed in one art period.
- B. Group Posters: are suitable for an advanced Grade Five and Grade Six. The class is divided into groups of five or six depending on the number of children in the class. While it resembles the individual poster in that all the rules of poster making are applied, it is different in that each child within the group contributes his special talent. He must also recognize the talents of others. This can become a good lesson in community living. While this type of project can be fun, it is time-consuming. It is also inadvisable to conduct such a project in a class that is poorly disciplined, since the children can get out of hand if the teacher is not in full control.
- C. Place Mats made from burlap bags can be an interesting project for Grade Six girls. On each place mat a tooth brushing reminder is illustrated with crayon. Afterwards each place mat is pressed with an iron to make fast the imprint. While the girls are working on place mats, the boys could be making wood plaques, which could be hung in the bathroom. On these plaques, a dental health rule could be illustrated with crayon.
- D. Another project which Grade Six will find interesting is the making of Booklets. Dental Health Rules can be illustrated in an animated fashion. Small manilla sheets are stapled together in the form of a book. Each page illustrates some aspect of dental health. Not only is it very creative, but art and language are correlated in the project.
- E. In the lower grades it is interesting to have the children Draw Pictures of a visit to the dental hygienist's clinic. After the children have heard the story of Mr. Tooth Decay (a germ who makes cavities), have them draw a picture of this germ. It certainly draws on the creative powers of the child.
- F. Murals can be made by all grades in the elementary level. A mural is a large picture which tells a story, in our case a story about teeth and their proper care. There are several types of murals. They can be the cut-out variety in which pictures are drawn or painted on small sheets of paper, cut out and pasted on a large sheet of mural paper or wrapping paper. Another type of mural is one in which the drawings are done directly on the mural paper.

Such work increases the child's power of retention and observation, provides seat work when regular class work has been completed, makes the dental health lesson more meaningful, teaches the children to work together and enables everyone to contribute his talent. There is no competitiveness in such a project. Consequently it is more enjoyable for the children, especially for the slow pupil.

- G. Recently a Grade Four made miniatures of the Dental Hygienist's equipment in plasticene. They placed this in a room which the girls had made from a box. Not only was this an act in manual dexterity, but it provided the children with an opportunity of becoming more aware of the names and purposes of the equipment. Consequently they were less fearful of it.

2. Besides projects in art one could correlate English with the dental health lesson.

- A. In Grades Primary to Two, it could be an Oral English Lesson, in which the child tells a story about his visit to the hygienist to the class. This gives the

child an opportunity of performing before his or her peers. Interest in such a lesson is increased if the talks are recorded on tapes.

- B. The older children could write a paragraph on such topics as "Why I Like The Dentist" or "Why I Don't Like The Dentist". Not only does this provide practice in paragraph writing, but it enables the child to express fears and hostilities.
 - C. Some classes are adept in making rhymes. This type of project correlates reading, language, writing and if illustrated, art.
 - D. Another project could be the writing of plays, which could be performed for the rest of the school. This project could correlate language, reading, writing, and drama. However it would be time-consuming and the teacher would have to be very creative in order to attempt such a project.
3. A most interesting project is having the children compose songs to the tune of Nursery Rhymes. Such a project correlates English, Music, Language, and Writing. The children's interest can be heightened if the songs are recorded. While it is time-consuming, the results are worth the effort.

The above is a summary of the work which has been attempted since December 1966. Most of the actual work on the projects was done by the teachers. However, if the hygienist initiates such work, she must take the time to commend the children for their effort, and show her appreciation by displaying the project in an area where all can see. If the hygienist fails to show this interest, then the project will not be as successful.

Some may wonder why such a project was initiated. It was felt that a dental health lesson was incomplete if some follow-up was not carried out. Such projects should make the hygienist's visit and lesson more meaningful to parents, teachers and children.

This project has several advantages.

- 1. It makes the community more aware that the hygienist is in the school and why she is there.
- 2. It provides for better relations between the teachers and hygienist since both are working closely for the betterment of the child. In other words the hygienist should feel more "in" with the group.
- 3. When the hygienist sees how much time a teacher will spend on such a project, then she in turn should bend over backwards to adjust her schedule to the teacher's convenience.
- 4. Such projects prevent the hygienist from getting in a rut, because she must be on her toes to come up with new ideas. The success of these projects will depend largely on her enthusiasm.

While these advantages do exist, it must be pointed out that such a program slows down the actual clinic work. But when one can see the added interest on the part of parents, teacher and children then it seems time well spent.

BRITISH COLUMBIA DENTAL WORKSHOP

Dr. S.J. Gallagher, B.Sc., D.D.S., D.D.P.H.

The 1962 dental survey of Vancouver children revealed some alarming statistics.

31%	of 7 - 15 year olds (combined)	- no caries defects
15%	"	- total dental neglect
54%	"	- partial treatment
35%	"	- poor oral hygiene

No caries defects means the children had all their dental decay restored. They are being adequately cared for. They could have orthodontic problems but otherwise they were in good dental health.

Total Neglect means the children had never been to visit a dentist. They were in obvious need of treatment.

Partial Treatment means the children had evidence of some restoration but they still required further treatment.

Poor Oral Hygiene means obvious material alba, green or orange stain, on two or more teeth.

Considering the above, the figures aren't something of which a city can be proud.

Who is involved with the dental health of these children? Who is responsible?

Parents or Guardians
Dental Profession
Education System
Mass Media
The Children
Health Department

Being in the health department I looked about for an area to assist in solving the problem. The Vancouver School Board and the Health Department work closely together so I approached the School Board with my suggestion.

Teachers are associated with children for five hours a day, five days a week, for many years. This is a considerable influence. Teachers, as members of the community, reflect attitudes of the community. Considering the teacher's intimate association with his students over an extended period of time, how does the teacher view the dental health of the student. Does the teacher believe the Health Department can assist him in helping the students achieve dental health?

To answer the above questions I proposed that a sample of teachers be interviewed and a workshop of teachers be held. With the approval and cooperation of the Vancouver School Board, both activities came to pass.

Twelve elementary teachers were interviewed on a one to one basis. Forty five to sixty minutes were scheduled for each interview. The technique attempted by the interviewer was a friendly, informal, inquiring approach rather than a testing of recall knowledge. Each interview was conducted in a similar manner. The schools were chosen by the V.S.B. Two schools were from a low socio-economic area and one from a high socio-economic area. One low socio-economic school had a Health

Department dental clinic in the school. The teachers for the interview were chosen by the principal. The kindergarten teacher from each school was chosen and then one from Grade 1 or 2, one from Grade 3 or 4, one from Grade 5 or 6 or 7. Twelve teachers were interviewed. The interviews were conducted on school time. The teacher's spare period was used or the principal arranged to have someone supervise the class during the interview. The following is a list of questions that were used as a guide for discussion.

1. From your experience as a teacher do you think the dental health of a child has much influence on his:
 Learning experience?
 Feeling of self-worth?
 Social relationships?
 Growth and development?
2. What percentage of children do you think are affected by dental disease?
3. What percentage of children do you think receive regular dental care?
4. What could be done to improve children's dental health?
5. Does the teacher have any responsibility to encourage dental health among his students?
6. What is there about dental decay that makes it different from most other childhood diseases?
7. What advances in modern dentistry do you consider the most significant?
8. How would you present the subject of dental decay to your class?
9. In your grade what aspect of dental health are the students most interested?
10. How many periods in the year do you devote to dental health teaching?
11. What could be done to keep you up to date on dental health?

The objective of the interviews was to test my hypotheses of teacher attitudes and to supply information as to what would be useful for the workshop.

Hypotheses

1. Most teachers have a negative attitude towards dental health.
2. Little or no dental health teaching is being conducted presently in the classroom.
3. Teachers have not defined their role in helping children achieve dental health.
4. Teachers do not feel adequately prepared to teach dental health.

Most teachers were ready to talk freely on the subject matter. It is difficult to tabulate the results of the interviews because of the variety of answers, but a pattern did develop from the answers.

1. Teachers do not have a negative attitude towards dental health. I did not include a dislike for dentists as a negative attitude for dental health.
2. Little or no dental health is being taught. Teachers do not like teaching health. They leave it to someone else or postpone it.
3. Teachers were not definite in this area. Some felt a responsibility, others considered they should not interfere with the parent's role.
4. The teachers were not aware of the body of knowledge that exists about prevention of dental disease. Further discussion in this area showed they used personal experience as a resource.

The Vancouver School Board arranged to release thirty teachers for a one day workshop on dental health. The principals again chose the teachers to attend. The interviewed teachers attended plus an additional six from each school. The Health Department provided the physical space in a health unit. The British Columbia Dental Association provided a luncheon which meant the teachers did not leave the building during the workshop.

The objectives of the workshop were as follows:

1. Inform the teachers that there is a dental health problem in Vancouver.
2. The problem is complex - involving many people and many factors.
3. There are ways and means of solving the problem.
Try to get a commitment from the teachers that they have a share in the solution of the problem.
4. What is the teacher's role and responsibility?
Can we assist the teacher in his role?

The technique used was information presented by a resource person followed by small group discussion. The teachers sat at tables of six. The tables were arranged so that the speaker was in the center of the total group. The walls of the room had displays of educational material. Each table had a large plastic molar, large toothbrush, denture model and some real extracted teeth. Cotton rolls dipped in beechwood creosote, eugenol, and thymol, were attached to fans spaced around the room. During the first presentation a taped recording of dental office noises was played.

The topics presented were:

1. Now Reality - The Problem - Public Health Dentist
 2. What's New in Preventive Dentistry - Dentist with a degree in Preventive Dentistry
 3. Interview with Dental Hygienist
 4. Factors Affecting Food Selection - Nutritionist
 5. Behavior Modification - Psychologist
-
1. The problem as presented was the result of findings of a survey in Vancouver in 1962. The percentages of children with "health teeth", partial treatment, and neglect were shown graphically. The causes as believed by the speaker were poor oral hygiene, food habits, lack of education, cost of dental treatment, and apathy.
 2. Preventive dentistry was discussed by comparing what was done 100 years ago and what we know today. Studies were described which showed the preventive value of such things as water fluoridation, change in food habits, topical fluorides, oral hygiene.
 3. The interview with a dental hygienist was conducted by a teacher who is involved with school board publications. The education and professional activities of the hygienist were discussed. The differences between a hygienist and a dentist were explained. The hygienist had visual aids and examples of educational materials that could be used in the classroom.
 4. The nutritionist discussed the influence food has in our daily lives with an explanation of how the habits develop. Factors involved are facts, feelings, finances, availability and communications.
 5. The psychologist gave examples of how the teacher could use classroom situations to influence behavior of students. He described the dangers of arousing fear and the advantage of the use of modelling behavior.

The presentations were interrupted by a rest "Break" consisting of raw vegetables, fruit, cheese, nuts, popcorn, a variety of fruit juices and fluoridated water.

The lunch provided was high in protein and had no refined carbohydrates. The lunch was served buffet style and included with the cutlery was one of the new disposable toothbrushes for each participant.

Following lunch the teachers were asked to discuss a number of questions listed in the program. The questions suggested were:

1. How do the teachers see the problem?
2. What would you do?
3. What do we do to overcome parent inertia?
4. Can we get parents and teachers together?
5. What can you do back in your classroom - and will you?
6. How can we assist you in your role?
7. Where should health in general and dental health in particular fit into the priorities of living?
8. What factors influence a child's action in the area of dental health?

In the discussion that followed it became evident that the teachers saw the dental problem as an emergency to be treated NOW rather than a problem to be prevented. There were many suggestions for improved treatment facilities, use of the mass media for education and the health department to educate parents before their children were old enough to go to school.

Only half of the questions were chosen for discussion. It was interesting to note they chose questions 1, 4, 5, and 6.

As a means of getting the parents and teachers together the issue of Fluoridation was suggested. Here was a topic they both could discuss and take action.

Several ideas for classroom activity were suggested. Snacks and evaluation of lunches were prominent. They suggested dental health be introduced into all subjects such as music, art, and social studies.

The Health Department was asked to assist in many ways. They wished films, film-strips, slides, models, brochures, both for the student and parent. The teachers saw the dental hygienist as a special educator who could periodically visit the schools. The hygienist should be used on Television to explain the care of teeth of the very young child.

At a follow up meeting of the resource personnel the outcome of the workshop was discussed. The psychologist stated the presentations were probably too dramatic, which raised the anxiety level of the teachers to the point where they considered the dental health of the children an emergency. The topic of fluoridation was mentioned only incidentally by the resource people of the workshop but the teachers picked it up as the obvious start of any plan of action. The teachers did not commit themselves to any share in responsibility for the solution of the problem. They looked to outsiders for assistance such as the dental hygienist, mass media. The teachers present were made aware of dental health but the expenditure of resource personnel effort was high in proportion.

C.D.A. AUXILIARIES SERVICE COMMISSION REPORT

Mrs. J. Gardner

While having no official position on the committee, nor a vote, we were allowed and asked to express our opinions on the matters that came up as well as giving our specific reports. This coming year, the structure of the committee is to change and there will be a representative to it from each province, hopefully, one who serves on their respective provincial Auxiliaries Services Committee. This could and should provide our Association's Special committee with a provincial liaison throughout the year.

Much of the first morning was spent on discussion of the establishment of Auxiliaries Services committees by provincial corporate members of the CDA and reports from those who have already done so this past year. B.C. and Quebec had each sent out questionnaires to their members for opinions on auxiliaries and related matters. Quebec's results were given but B.C.'s was not complete at the meeting date.

Dr. R. A. Connor reported on the matter of the Health Resources Fund that the federal government has set aside for school facilities for all health fields. (It was money from this fund that allowed UBC Faculty of Dentistry to complete its building program.) The Federal government has decided that studies should be done on health manpower in all health fields and a government committee is formed and will have, at the present, only 3 representatives from all the health fields. One from medicine and one from nursing have been named to date. As yet no meeting date of the committee has been scheduled. At the present time, dental hygiene will be represented by the dental profession.

The last two items on the morning agenda were a change in the CDA Policy Statement regarding auxiliaries and a discussion of the ADA action on their Board of Trustee's resolution (see answer to #7 in our questionnaire). This latter discussion was a long one and from it developed the idea that the main thing the committee hoped to accomplish was a recommendation regarding deletion of specific duties of auxiliaries, and if this committee's recommendation was accepted by the CDA at their Annual session, it would require a change in the CDA Policy Statement.

That afternoon opened with my presentation of CDHA views. The basis of my report was determined by results from the questionnaire, but since this was limited, I also had to utilize information from other sources, information that from discussions and correspondence, I knew were not just personal views, but those of many of our Association. I was somewhat disappointed that only slightly over 1/3 of our members felt it important enough to return the questionnaire. Dr. Dunn, Chairman of the CDA council on Education specifically asked for our views on what he called "two levels of hygienist", meaning those trained in Universities and those who would or could be trained in community colleges or technical schools. I repeated our view that dental hygiene remain a University course, whether a two year diploma course or a four year degree program. That we would accept a switch to other facilities reluctantly and with great reservations only if this was the only way to meet the need for a greater number of hygienists. That the CDHA had endorsed the action of the ODHA in supporting the establishment of a degree program in dental hygiene at the University of Western Ont.; the continuation of the present two year diploma courses within a faculty of dentistry; and post graduate education for hygienists.

Discussion then reverted back to how best to achieve a workable resolution regarding deletion of duties.

A report by Dr. Downton was given in the afternoon on the Dental Technicians Conference. For your information, technicians are most concerned that dental assist-

ants and dental hygienists seem to be allowed to do illegal procedures under the supervision of the dentist while dental technicians were not. They recommended that restriction of all auxiliaries should be followed. Discussion followed this, but no special action was taken on the point and the full report of Dr. Downton was adopted.

The final time was spent in preparing the resolution on deletion of specific duties and the delegation of duties. It reads as follows:

Whereas, inherent in dental licensure is a recognition of the professional competence and integrity of the one upon whom license is conferred, and

Whereas, when a dentist acquires the right to engage in practice he assumes a broad spectrum of professional and legal obligations and responsibilities such obligations and responsibilities being consistent with standards established by professional brethren of good repute and

Whereas, these obligations and responsibilities extend not only to the professional attentions given by the dentist himself, but also to the services rendered by those employed by him and

Whereas, only the dentist is qualified through education, training, experience and licensure to accept ultimate responsibility for dental treatment services rendered to the public and further,

That in assuming this responsibility, it is the right of the dentist under the regulatory oversight of the licensing authority by which he is licensed, to delegate to dental auxiliaries over whom he exerts effective supervision and control such duties as do not require for their performance the professional knowledge and skill of the dentist and as do not require for their performance the professional knowledge and skill of the dentists and further,

That it be respectfully recommended to provincial licensing authorities to extend every effort to create such legal environment for the practice of dentistry that will make possible the effective implementation of the above principle and further,

That as a fundamental requirement for the statute and regulations under which dentistry is practiced, the principle of the ultimate responsibility of the dentist be clearly and unequivocally enunciated and that a serial listing of services which might legally be performed by auxiliary personnel be deleted.

This recommendation is as broad as the one presented to the ADA in November. Dr. MacIntosh and at least two other members of the committee and myself expressed concern that no mention was made of the education standards of the auxiliaries that would be doing the delegated duties. This resolution contains no qualifying statement as to need of educational standards as did the ADA resolution. It was my feeling and opinion that it would be a step backward to permit on the job training of auxiliaries to do expanded duties.

I greatly appreciate having had the opportunity of attending this meeting. I found the members interested in hearing our views and opinions. While I am reserved in my acceptance in total of the recommendation adopted, the chance to voice our opinion in the matter was most encouraging. I'm certain that by showing that we too are concerned with finding a solution was vital. I hope that this first opportunity will expand into others in the future. This certainly must be the prime goal for future executives of the CDHA. This quote sums up my feelings, "If you do not think about the future, you cannot have one."

NUTRITIONAL COUNSELING AS AN APPROACH TO CARIES PREVENTION - A REPORT AND SUMMARY

M. Bondarchuk, B.A., R.D.H.

On Saturday, March 30, 1968, several hygienists had the opportunity of meeting and hearing Dr. Abraham E. Nizel give a presentation on nutritional counseling as a rational and practical approach to caries prevention. This all-day affair was sponsored by the Niagara Peninsula Study Club, was held in Toronto and was open to the dental profession, their hygienists and assistants.

Dr. Nizel is perhaps best known to us through his excellent book, *The Science of Nutrition and Its Application to Clinical Dentistry*, along with other scientific papers. He is an Associate Professor at Tufts School of Dental Medicine, Boston, and is Research Associate in the Oral Science section of the Nutrition and Food Science Department at M. I. T.

The four major areas that Dr. Nizel discussed were:

1. the concepts of nutrition
2. the relation of nutrition to caries
3. the technique of counseling
4. the actual counseling

After briefly defining and reviewing the basic concepts of nutrition, Dr. Nizel mentioned examples of some misconceptions held by many people. The popular concern in weight reduction had led many to drastically reduce their fat and carbohydrate intake or to indulge in food fads. Some fats and carbohydrates are necessary to meet the body's energy requirements. Otherwise the energy requirements would be derived from proteins before they are designated for repair. With respect to dental caries it is the quality of the carbohydrate that is important; sugar intake bears a direct relationship to caries incidence whereas starch does not.

Although it is necessary for the dental profession to understand the underlying basis of nutritional concepts, it is also important for this to be translated into practical terms for the patient. Thus nutrients are related in terms of qualitative and quantitative foods. Qualitatively, food is divided into four main groups -- milk, meat, fruits & vegetables, and bread and cereal. Quantitatively, we refer to dietary standards. One standard is the Recommended Daily Allowance (R. D. A.); if the food intake is less than the R. D. A., then malnutrition occurs. The other standard is the Minimum Daily Requirement (M. D. R.); if the intake is less than the M. D. R., then there is a deficiency disease. This is rare in North America. R. D. A. equals 2 M. D. R. The R. D. A. of nutrients is translated into amounts of servings of the qualitative food groups, such as those in Canada's Food Guide.

The second area under discussion was the relation of nutrition to dental caries. There are certain underlying conditions which influence caries resistance and which are largely uncontrollable. These are Environment Factors, geographic, socio-economic status etc.; and Host Factors, such as age, sex, heredity etc. It is in these areas that the 'why' of the diet should be appreciated, such as the need for the inclusion of minerals during the lactation period for optimal benefit in caries resistance, rather than at a later time. Then there are the Agent Factors which are the local factors present in the mouth. The Agent Factors include, bacteria present in the oral cavity with a predilection for tooth surfaces, and food in local contact with the tooth. Studies have shown that the presence of bacteria is mandatory in order to produce dental caries (chemico-parasitic theory, W.D. Miller). But to be biochemically specific the reaction is such:

Streptococci + sucrose----- polysaccharide (dextran + levan)

dental plaque.

storing mechanism for sucrose.

Sucrose is a monosaccharide, a small molecule, able to enter and be stored in the dental plaque; whereas starch is a polysaccharide which does not act with streptococci and thus operates as a buffering mechanism and cannot enter and be stored in the dental plaque.

The emphasis is then on the presence of sucrose in the diet, for sucrose is necessary for the initiation and development of the caries process. Sucrose can be stored or utilized immediately by acidogenic bacteria. Time, (at or between meals), frequency rather than amount, and form (solid, sticky, liquid) of sucrose are also directly related to caries activity.

Other nutrients currently under study with respect to caries activity are phosphates, fluorides, and casein. Studies show that the addition of phosphorus to a cariogenic diet produces a decrease in caries. From other experiments using various phosphates, it has been postulated that the mechanism may be a buffering activity and a common ion effect. That is, the diet supplies the oral bacteria with phosphorus for its activity and thus avoids taking phosphorus from the tooth enamel. Dr. Nizel's work with sodium phosphate in cereal and candy has shown a 20-30% reduction in interproximal caries. Although the value of fluoride included with food intake is widely accepted, the underlying mechanism is still under study. The commonly held hypothesis was that fluoride prevented the dissolution of enamel by combining with it to form a fluoroapatite which is less soluble in acid. But lead and zinc work the same way and do not prevent dental caries. The current hypothesis is that fluoride forms a stabilizing apatite having a re-precipitation or remineralizing effect as opposed to caries producing a demineralizing effect. As well, new experiments have shown casein, a phospho-protein added to milk, to be a cariostatic factor.

Dr. Nizel stressed that there is no one answer, but that food generally is the cause of dental decay. In order to produce effective results through diet counseling it is necessary to motivate the patient to accept and to continue to follow the prescribed instructions. Prime motivation factors are:

1. the conviction of the dental team that diet is a meaningful method of dealing with caries
2. appealing to the aesthetic and health advantages
3. reduction in future restorative needs and thereby a reduction in dental costs
4. a fee for counseling services will give value to the service
5. a monitoring device, such as a swab test to give quick visible evidence that dietary co-operation has made a desirable change in the oral environment.

Dr. Nizel repeatedly stressed that each case is individual and that the analysis and management of the problem should be based upon a careful collection and deduction of the individual facts. Furthermore, for the message to be effectively communicated the advice must be simple, clear and objective with as little altering of the patient's basic food preferences as possible.

Dr. Nizel's procedure begins with the careful selection of the patient. Diet counseling involves at least four visits.

1. The first visit may be conducted at the chairside and involves writing down what the patient had eaten in the twenty-four hours prior to the appointment. The patient is given specific instructions. When completed, the patient returns the food intake diary for study.
2. The second and third visits are also at the chairside during the time allotted for other services. The purpose of these visits are primarily to understand the 'whys' of the patient's diet.
3. The final visit is the actual counseling visit and is not held at the chairside. The time is devoted entirely to the patient's diet.

Dr. Nizel demonstrated this final visit with the co-operation of a family who had previously completed the food intake diary. In this case the diet examined was that of an eleven year old boy. Dr. Nizel had the patient perform the tallying to become actively involved in dramatically separating the basic foods from the additional foods as well as vividly demonstrating the amount, and frequency, of sweets. This was done by circling with a red pencil all foods with sugar in or on them.

The adequacy of the fundamental foods is then calculated by comparing on the Diet Evaluation Summary Sheet the actual intake with the Recommended Daily Allowance. On the sweets intake section of this sheet Dr. Nizel instructed the patient to tally the form and the frequency of the food. If each check mark represents approximately 20 minutes of acid production the number of exposures times 20 will show the number of minutes per day his teeth are exposed to a potentially decalcifying environment.

A third dietary sheet was prepared containing personalized instructions for the patient which took into consideration the 'whys' along with the 'whats' in the diet. This data was derived from the first diet sheet. As Dr. Nizel went over the prescribed diet, he invited discussion from the persons involved with regard to preferences of foods substituted for sweets. Follow up visits were recommended about six weeks after the last visit along with a food intake diary sheet for re-evaluation. Dr. Nizel has found that resistance to the recommendations is experienced when an increase in quantity is suggested and thus recommends an increase in quality to be the primary aim. He suggests that, rather than accentuate a "food weakness" by suggesting ways of indulging it, a substitute food should be suggested.

During a short interview with Dr. Nizel, the role of the dental hygienist in dietary counseling was discussed. He expressed disappointment in the fact that she has not exercised her full potential in this area nor has she been forceful enough in making the dentist fully aware of the ability to do so. He continued by suggesting that a beginning could be made by demonstrating her ability to conduct dietary counseling effectively by offering to select a patient in the office and follow it through for trial purposes. This could be considered food for thought.

Clarification and additional detail of the material covered may be found in Dr. Nizel's articles in Dental Clinics of North America, July 1962, the Journal, Southern California Dental Association, Vol 35, No 10, October 1967, and in his textbook, mentioned earlier.

A.D.H.A. ANNOUNCES ASSOCIATE MEMBERSHIP

The 1967 House of Delegates of the American Dental Hygienists Association added a new membership classification, Associate Members, to its Bylaws. This enables Canadian Dental Hygienists to become members of the A.D.H.A., thereby becoming eligible for all of their insurance programs. The fee for this membership is \$15.00 and includes the same rights and privileges as Active Members.

C.D.H.A. POLICY STATEMENT - FLUORIDATION

Tooth decay, by affecting the vast majority of people in Canada, has come to be recognized as one of the major public health problems of our time, and

Studies covering a period of over thirty years under the widest variety of controlled conditions have marked fluoridation as one of the most widely studied of public health procedures, and

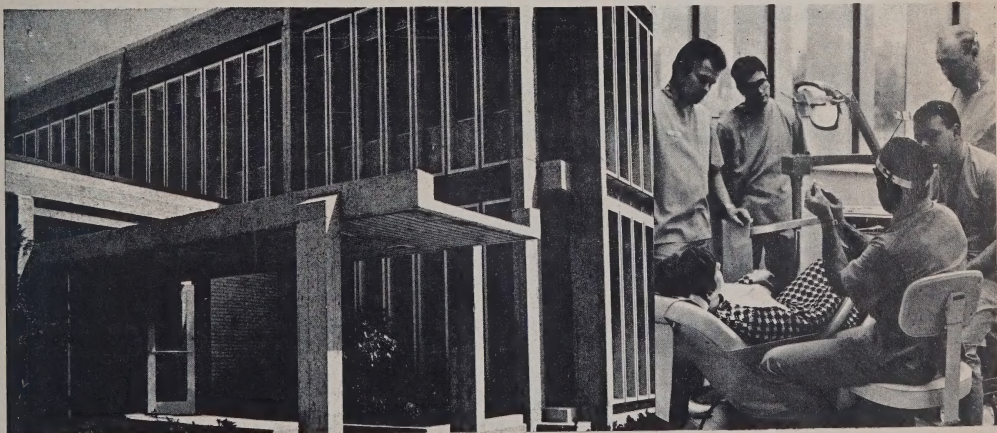
Such studies reveal that fluoride in the recommended amount of one part of fluoride to one million parts of water causes no ill effect and is effective in reducing tooth decay by approximately two-thirds, and

Fluoridation benefits children and the benefits extend into adult life, therefore

The Canadian Dental Hygienists' Association endorses water fluoridation on a community basis as the most logical approach in the prevention of the disease of dental caries and recommends to the people of Canada that communities having a public water supply adopt a procedure for adjusting the fluoride content of their water supply to a level considered optimal for the maximum prevention of dental decay.

OFFICIAL OPENING OF THE J.B. MacDONALD BUILDING

The John Barfoot MacDonald building at the University of British Columbia was officially opened on March 20, 1968. This health services building houses the principal activities of the Faculty of Dentistry. The building, named after Dr. J.B. MacDonald, dentist-scientist-administrator at U.B.C. is a handsome one indeed. In it is space devoted to classroom instruction, laboratory research, and clinical practice. The Faculty of Dentistry at U.B.C. is also incorporating into its program a School of Dental Hygiene to be opened in the near future.



John Barfoot MacDonald Building

Modern clinic equipment at U.B.C. makes visits easier for student and patient.

GINGIVAL TISSUE HEALTH WITH HAND AND POWER BRUSHING: A RETROSPECTIVE WITH CORROBORATIVE STUDIES

J. H. Manhold, Jr.

The Journal of Periodontology Vol. 38 No. 1 - 1967

In previous studies of the comparison of electric and hand brushing it was determined that there is no significant amount of formation of keratinized tissue with either method. The study done on the effects of tissue metabolism demonstrates that there is an absence of pathology with both the electric and hand brushing methods.

To compare electric and hand brushing in the removal of debris, dental students were chosen as subjects. The amount of debris removed was measured by the contents expectorated following brushing by each subject. It was found that the electric brush provided a total debris clearance of 16 mg. over the hand brush. On an individual basis, 63% of the subjects produced better clearance with the electric brush; 36% had better results with the hand brush; one subject had identical results for both. A comparison of hand and electric toothbrushing in calculus formation was studied. During alternate three month periods of calculus formation on the subjects, using first the hand brush, then the electric brush, the following conclusions were determined - 81% of the subjects had a lower calculus rating using the electric brush, 8 subjects fared better with the hand brush and one remained unaltered.

From gathered data, the superior state of gingival health with the electric toothbrush is attributed to its superior cleaning action and the increase in fluid flow from the increased stimulation provided by the electric brush.

EFFECTS OF INSTRUCTED TOOTHBRUSHING ON CLEANLINESS OF TEETH AND D.M.F. : AN EIGHTEEN MONTH STUDY

P.D. Toto, V.J. Sawinski, C. Evans

The Journal of Oral Therapeutics and Pharmacology Vol. 3 No. 5

The study was conducted on 2 groups of school age children to demonstrate the effects of manual and cordless electric toothbrushing upon the cleanliness of the teeth and the incidence of decayed, missing and filled teeth.

The group that was given instructions showed equivalently clean teeth and a reduction in D.M.F. The uninstructed or control group showed no decrease in oral debris. The instructed groups showed greater reduction in D.M.F. than did the control group. Instructed electric toothbrushing resulted in 10 per cent greater reduction in D.M.F. than did uninstructed manual toothbrushing.

This study shows that instruction in the proper use of the toothbrush leads to significantly cleaner teeth. Since clean teeth are considered beneficial to oral health, careful instruction in toothbrushing is of prime importance.

DIMENSIONS IN DENTAL HYGIENE

Pauline F. Steele, B.S., R.D.H., B.S. (Ed.), M.A.
Lea & Febiger - Philadelphia 1966.

In recent years, texts designed for student dental hygienists have become available in many fields such as dental materials, oral pathology, and clinical dental hygiene practice. These have been welcomed by dental hygiene educators, but many have felt the need of a single synoptic text as well, which would provide a focus for the dental hygiene student. "Dimensions in Dental Hygiene", edited by Pauline Steele and containing chapters by fourteen highly qualified contributors, attempts to meet this need.

This book contains a tremendous amount of factual information and some stimulating discussions. As well as providing an understanding of current concepts in the field of dental hygiene, some chapters include insight into trends and areas of investigation in dental research. The book is well illustrated and most chapters have excellent bibliographies.

Unavoidably, there is a great variety in the level of approach in the different chapters. The approach selected, however, is usually justified in the light of material and background provided in various aspects of the dental hygiene curriculum. The chapter on oral pathology, for example, presupposes an understanding on the part of the student hygienist of many terms and pathological processes; an understanding which the student hygienist would acquire in a course in oral pathology with the assistance of another text. Oral prophylaxis and oral physiotherapy, however, are discussed in such a way that these chapters could be used very early in the course of studies.

To deal competently with the "dimensions" of dental hygiene in one book requires an economy of words from each contributor and a discerning editor. Some areas of discussion must be deleted entirely, others drastically condensed, and the reader may or may not agree with the editor's decisions. One might readily accept the exclusion of such topics as dental materials and radiology (the editor has happily kept this book from being a manual of technique) and yet find regrettable the absence of a more detailed discussion of nutrition and its relation to dental health.

Perhaps a more serious fault lies in the selection of sequence of chapters. It is hard to understand, for example, why the chapter on oral prophylaxis is not preceded by the chapters on periodontics and dental deposits, which would provide background and understanding for it.

On the whole, Miss Steele and her contributors are to be congratulated on this book. Dental hygiene students will find it provides a means of relating various areas of curriculum to each other, and educators who believe that the hygienists' education should be based on understanding rather than on rote learning will find it most useful.

FIFTY-TWO PEARLS AND THEIR ENVIRONMENT

Joseph C. Muhler, D.D.S., PH.D., F.A.C.D.
Indiana University Press,
Bloomington & London

This excellent book starts by asking the question "Why Dental Health Education?" After answering this in a methodical and convincing manner Dr. Muhler begins to talk to children, adults and contemporaries. In the course of the 14 chapters, Dr. Muhler deals with the tooth from its formation to its loss. Chapters on artificial dentures, on nutrition and on fluorides present a complete picture of the dental environment. Dr. Muhler himself states that this book is designed for lay-people and as such it can be understood by everyone. It especially answers common questions about dental maladies, and general diseases of the oral cavity. Accurate illustrations help the reader to grasp the exact picture of each specialty or problem presented.

This inexpensive paperback should be a part of dental waiting-room literature. Or better, it should be part of your patient's home library.

PUBLIC HEALTH SERVICE PUBLISHES FLUORIDE BOOK

The U.S. Public Health Service has released a new source book entitled "A Guide to Reading on Fluoridation". Compiled by the Division of Dental Health, the book contains an annotated bibliography, listing over 60 titles on fluoridation literature. Most of the research papers annotated were published within the last ten years.

Single copies of the pamphlet, P.H.S. publication No. 1680, are available from the Division of Dental Health, U.S.P.H.S., 8120 Woodmont Ave., Bethesda, Md., 20014.

Quantities of the booklet may be purchased at 15¢ per copy from The Superintendent of Documents, Government Printing Office, Washington D.C., 20402.

POSITIONS AVAILABLE

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Wanted - Dental Hygienist to serve three dentists, five days per week on an alternate basis. Cavitron. Past hygienist highly satisfied but left to be married. Replies to Dr. A.J.S. Prothero, 306 - 4900 Kingsway, Burnaby 1, B.C.

Wanted Dental Hygienist - Top salary, three week yearly holiday, fare reimbursed after one month employment, available living accommodations. Apply Dr. J. Thorsness, 1320 Fifth Avenue, Prince George, B.C.

Dental Hygienists: Vancouver Calling!- Position available June 1, 1968 in a private practice where a hygienist has trained the office and the patients for the past three years. Top salary paid in air-conditioned office in modern convenient location. No provincial board examinations required. Further details by request. Dr. Edward I. Slakov, 220 - 5655 Cambie Street, Vancouver 15, B.C.

Hygienist - Progressive group on Vancouver Island urgently requires services of hygienist commencing July 1968. Good conditions of service and high remuneration. Write to Dr. J.K. Philp, 301 Festubert St., Duncan, B.C.

Dental Hygienist - City of Vancouver - An immediate vacancy exists in the Dental Services Division of the City of Vancouver for a qualified Dental Hygienist.

The incumbent will participate in a varied program of preventive dental services by instructing pre-school and younger school-age children, parents and elementary school teachers in the principles of dental hygiene and give lectures on subjects related to dental health such as nutrition, oral hygiene, between-meal eating habits and the importance of early and regular dental care. Duties also include conducting oral examinations in health clinics and elementary schools, cleaning and polishing teeth and administering fluoride applications.

Candidates must hold a recognized diploma from an approved school of Dental Hygiene and be eligible for a license to practice as a Dental Hygienist in the Province of B.C. Some practical work experience is preferred but not essential.

Salary range is from \$5,568 to \$6,648 per annum and is currently under negotiation. Fringe benefits are complete and amount to approximately 20% of gross salary. The present duration of the appointment is 6 months, pending a review of permanency in the near future.

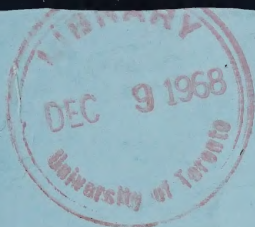
Application forms should be obtained from and returned to the Director of Personnel Services, Vancouver City Hall, 453 West 12th Ave., Vancouver 10, B.C. as soon as possible.

DENT



THE CANADIAN DENTAL HYGIENIST

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1968
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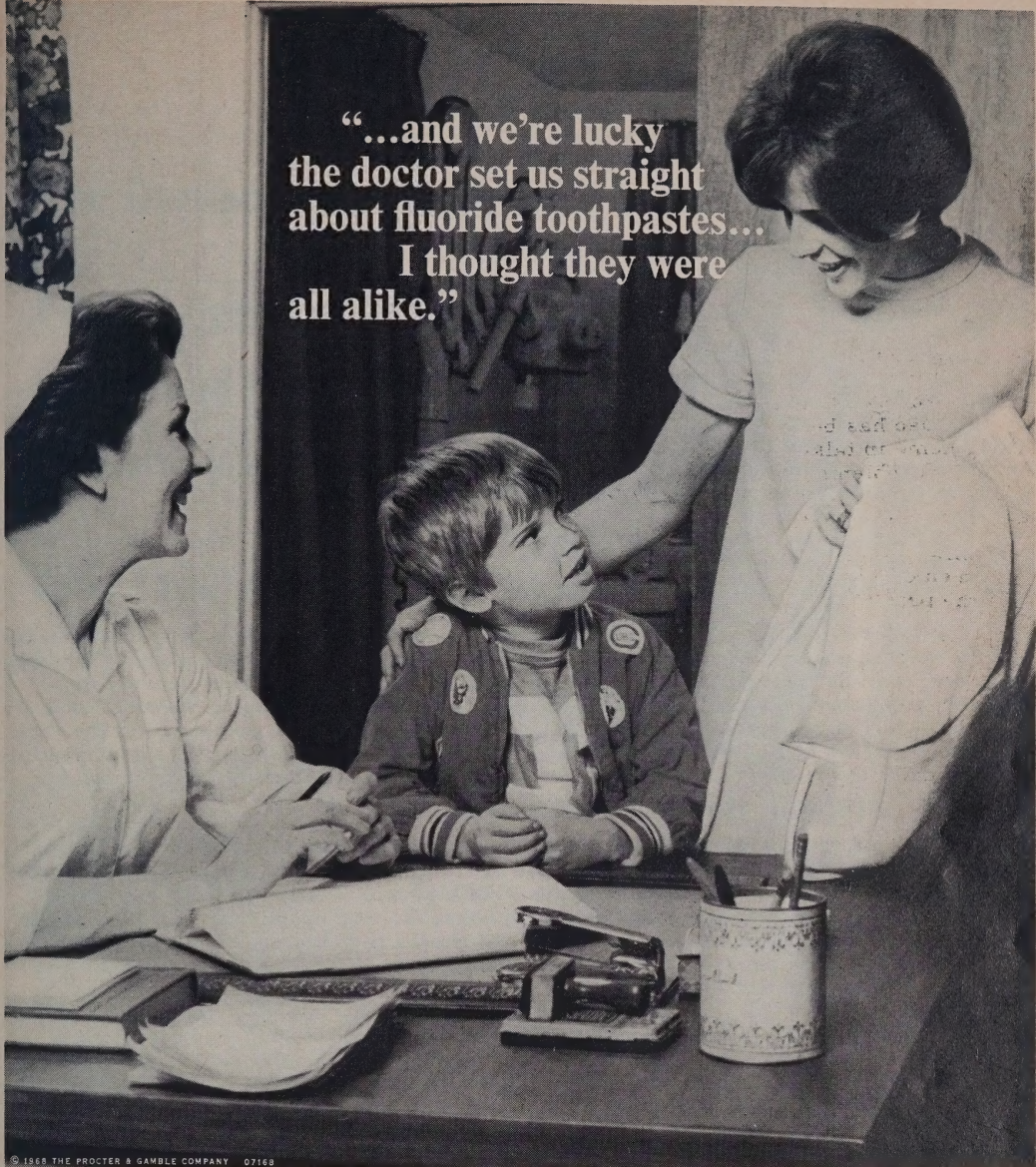
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TABLE OF CONTENTS

	Page
President's Message	4
Editorials - On the Numbers of Hygienists	6
Our Association and Our Journal	7
Ode to a Dental Hygienist	8
C.D.H.A. Historian	8
Vital Statistics on Clinical Dental Auxiliaries and the Potential Effect of Changing Concepts of Dental Health Care on the Future of Dental Hygiene	9
C.F.D.E.	14
Committee on Dental Auxiliaries	15
C.D.H.A. Brief to the Committee on Dental Auxiliaries	16
Remember	18
5th Annual Convention - A Diary	19
Panel Discussion	21
Table Clinics	22
Continuing Education Courses	23
Recipe for a Convention - 1969	24
C.D.H.A. News	25
New Dental Health Book Available	26
C.D.H.A. Executive	27
Constituent News	28
Positions Available	29

INDEX TO ADVERTISERS

Proctor & Gamble Co.	3
Dentsply Canada Ltd.	5



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(3) in a fluoridated area — J.A.D.A. 73:853, 1966.

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PRESIDENT'S MESSAGE

Mrs. Shelly Altman, B.A., R.D.H.
President, C.D.H.A.

We have heard much in the past few months on the subject of 'national unity'. This phrase has been used to refer to the people of Canada. I would like to utilize this same theme in talking about The Canadian Dental Hygienists' Association. In many ways the problems encountered by both are very similar.

National unity, whether within an association or a country, represents the very foundation for its existence. Without this solid base, there is no hope of a strong and organized group.

I believe that the best way we can achieve a national unity in our association is to first remember we have a common link, our profession of Dental Hygiene. Whether we come from the East or the West, from urban or rural areas, from densely or sparsely populated regions, from areas with accepting or disparaging views of dental care, regardless of our racial, ethnic or linguistic backgrounds, we share in the knowledge that we can contribute something to the people of Canada. This contribution is made daily in the form of health services, education and information provided for the public.

Once we realize we have a common link, we must then look to the benefits of belonging to a group, one which will provide something for all hygienists. The Canadian Dental Hygienists' Association is such a group. We try to keep members informed on new developments, and aware of changes. We encourage new recruits to our profession. We have established a Code of Ethics to guide our members. We formulate policies on pressing issues. Most important of all, we try to express the best interests of each and every hygienist in Canada.

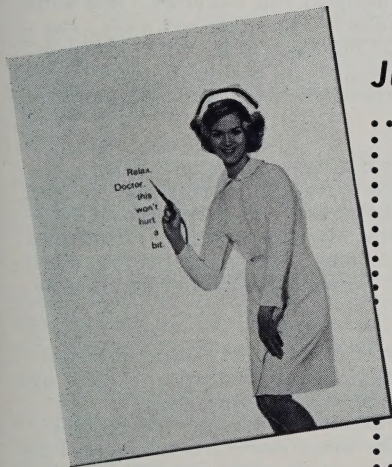
The C.D.H.A. is but five years old. We have come a long way since the beginning but there is a great deal to do in the future. The challenge of tomorrow can only be dealt with if we join forces today. To begin, we need YOU --- your ideas, your ambitions, your enthusiasm, and most of all, your PARTICIPATION.

Do you think that you dare miss out on helping to shape our future? Do you realize that every voice, however small, is significant? Did you know that the C.D.H.A. is the voice for hygienists across our country--from Atlantic to Pacific? If you wish to be heard, join our plea for national unity --- unity in participation, interest and involvement. You will be glad you did.

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ON THE NUMBERS OF HYGIENISTS

The dental hygienist is the only auxiliary of the dental profession that is licensed to work in the mouth. Her time, spent mainly on prophylaxis, fluoride application, and patient counselling, is in great demand. So great, in fact, that in many instances other office personnel are filling the practice needs and performing the services which are traditionally and lawfully assigned to the dental hygienist. This fact in itself emphasizes the importance of, and the need for, an auxiliary who is trained to perform preventive services.

Taking a look at present figures (1), there are about 320 hygienists in practice today; one for every 22 dentists or one for every 64,550 Canadian citizens. According to projections based on U.S.A. figure, by 1980 there will be quite a change in the picture of dental hygiene. There will be 1300 hygienists; one for every 8 dentists, or one for every 19,350 people. This future picture, while better than the present one, is far from ideal.

Suppose that the C.D.A. Children's Dental Health Plan were to go into effect on schedule. During the first year, all three year old children would be cared for. This is 1,250 eligible children per hygienist in practice (2). And by 1980 there will be 4,250 children per hygienist -- a staggering ratio. These figures take into account only the children included in the health plan. They make no allowance for adults or private practice patients.

With the present schools of dental hygiene operating at full capacity, and some of them expanding their facilities within the bounds of planned building projects, the most we can expect by 1980 is 1300 hygienists. Those 1300 hygienists will be three times as busy as the 320 hygienists of today. There must be, in order to preserve the present ratio (not to mention improving on it), about three times the anticipated output of present schools.

While dental hygiene educators would agree that the best and first choice of institution for a school of dental hygiene would be a university, these facilities do not exist in the proportions in which they are required. The first step to expansion of facilities could be, of course to begin programs of dental hygiene in university dental faculties where none exist now. Saskatoon, Sask. and London, Ont. are two possibilities that come to mind immediately. Building projects should be initiated as soon as possible to facilitate increased enrollment.

In the United States, dental hygiene education is carried on in junior colleges as well as in universities. Would this not be a possibility in Canada, too? There are 42 such colleges across the country now, and more are in the planning stages. To expand into the junior colleges would alleviate space problems and at the same time increase enrollment. These institutions would be able to offer some basic courses in the social sciences and humanities, so that the well balanced present educational standards would not change. This course of action would also satisfy those who are opposed to technical school training centers.

The Hall Commission Report of 1965 did not consider the dental hygienist to play a significant role in preventive dentistry. We presume that this conclusion was reached because, up to that time, there were very limited numbers of hygienists in Canada. Since then, however, the number of hygienists has increased considerably

(1) C.D.A. Dental Health Plan for Children, table 3, page 21

(2) C.D.A. Dental Health Plan for Children, table 9, page 28

(from 88 to 320) and we know that the dental hygienist is a valuable asset to any dental office or public health unit.

Greater numbers of this auxiliary, through expansion of existing facilities and the creation of new schools in the appropriate settings can provide the crucial services required to give the future generations of Canadians a happy healthy smile.

OUR ASSOCIATION AND OUR JOURNAL

All of the positions in the Canadian Dental Hygienists' Association are filled voluntarily. There are no office buildings, no secretaries, and no errand runners. In this small beginning of a national, unifying organization everyone must carry his share of the responsibility.

Of the over 300 members of the C.D.H.A. only a few dedicated souls annually accept positions on the executive, the board of directors, and as committee chairmen. Have you noticed how the same names appear time and time again? We think that dedication to one's organization can only stretch so far. To expect momentous tasks and near-miracles from part-time volunteers just doesn't make sense.

This journal was first printed one year ago. The first issue was very decidedly a regional product. Most of the articles were by local hygienists and research articles were from the University of Manitoba Faculty of Dentistry. This is understandable -- our committee was just beginning to grasp the potential impact of a national journal and found it necessary to have all participants within conversation distance.

For the contents of subsequent issues this excuse (or reason, if you prefer) is no longer valid. You, as members of the C.D.H.A. and regular recipients of the journal are aware of the task of the editorial committee. You must also be aware of the fact that the journal is still very provincial, rather than the national product that it should be.

It is not fair to the editorial committee to expect them, after a full working day, to spend hours cajoling people to produce, writing comments, editing copy, supervising publication and mailing the finished journal. Isn't this asking a bit too much of dedication?

It is not fair to the province of Manitoba and the few hygienists there. To have the C.D.H.A. executive working on the journal in addition to their other organizational responsibilities is incomprehensible. Surely there are many articulate hygienists elsewhere who deserve a chance to contribute.

It is not fair to you as Canadian hygienists to have the journal with an obvious provincial bias. Your opinions are important, and your ideas should be shared. The work in research centers and in organizations in all provinces is worthy of note -- in your national journal.

It is not fair to the companies who buy advertising space in our publication. We cannot expect to compete in the world of journalism (for that is where we are headed, ready or not) unless we can offer a first class product. They need us -- after all, what better place is there for hundreds of Canadian hygienists to read about a bright new product? Quite frankly, we need the advertisers to keep going. Wouldn't you agree that both sides deserve a fair bargain?

Donate some of your time to this mutually beneficial cause. Give your elected editorial chairmen some help. Assist her to find articles, research journals for review, and write up the provincial news. We are all in this together, and your help is needed.

Remember that we, as a national organization, have a place of growing importance in this country. If we expect to be recognized by others (and that included the advertisers in this journal, as well as health organizations and government committees) then we must recognize ourselves as a total group rather than as individual dental hygienists. Begin by doing your share.

ODE TO A DENTAL HYGIENIST

Hygienist, in your dental chair
I sit without a single care,
Except when tickled by your hair.
I know that when you grab the drills
I need not fear the pain that kills.
You merely make my molars clean
With pumice doped with wintergreen.
So I lean back in calm reflection,
With close-up views of your complexion,
And taste the flavour of your thumbs
While you massage my flabby gums.
To me no woman can be smarter
Than she who scales away my tartar,
And none more fitted for my bride
Than one who knows me from inside.
At least as far as she has gotten
She sees how much of me is rotten.

Earnest A. Hooton

C.D.H.A. HISTORIAN

The C.D.H.A. is now receiving applications from interested parties for the newly created position of historian.

This person will be in charge of keeping back records, files and other items not in use, in an organized manner. Since the association is accumulating more data each year, it is essential that one place be found to keep this material.

The position is a relatively permanent one. No specific terms of office will be laid out. By having all non-current material in one area there will be less chance of files being lost or mislaid and it will be convenient to locate any desired material when necessary.

Interested parties are asked to apply to the Secretary of the C.D.H.A.

Miss Jill Downton,
457 Winchester Street,
Winnipeg 12, Manitoba.

Please have applications or inquiries in by November 20th.

SOME VITAL STATISTICS ON CLINICAL DENTAL AUXILIARIES AROUND THE
WORLD AND THE POTENTIAL EFFECTS OF CHANGING CONCEPTS OF
HEALTH CARE UPON THE FUTURE OF DENTAL HYGIENE*

Miss S.B. Amer,
Sr. Dental Hygienist, Dental Health Division,
Department of National Health and Welfare, Ottawa, Ontario.

At the May Convention of The Ontario Dental Hygienists' Association, I gave a short talk on The Changing Concepts of Health Care and Their Potential Effects Upon The Future of Dental Hygiene. Today, I would like to discuss this subject again along with what might be termed The Vital Statistics on Clinical Dental Auxiliaries Around The World. In other words - what is the present and future place for dental hygienists and other similar auxiliaries within dentistry?

We are all familiar with the profession of Dental Hygiene as it exists within Canada and the United States, but we often are not so keenly aware of the types of trained clinical auxiliaries including dental hygienists which exist in other parts of the world. Looking at ourselves in a world-wide perspective gives us an indication of our relative importance internationally and of what other nations consider suitable auxiliary duties to meet the dental health needs of the population.

Starting at home, in Canada we began training dental hygienists in 1952, and as you all know we have four dental hygiene schools producing graduates at present with the University of British Columbia to enter its first class this fall I believe. Licensed dental hygienists number somewhere over 400.

The largest number of dental hygienists within any one country exists to the south of us in the United States where the first dental hygienists in the world were trained in 1913. As of June 1967 there were 57 institutions conducting accredited dental hygiene educational programs¹ and a true count of active dental hygienists, eliminating multiple registrations by an individual in more than one state in 1964 gave the figure of 14,500 active dental hygienists.² The current figure, of course, would be much higher.

In Britain there were seven training schools for dental hygienists in 1964 and 250 dental hygienists registered to practice.³ Britain's programmes for dental hygienists started post World War II - first within the Armed Forces and eventually in the civilian settings. The dental hygiene curriculum, although only approximately nine months in length as compared to the North American two academic years, is more compact with less free time and vacation periods.⁴ We, as Canadians, tend to think of the United States, Britain and Canada as the three major concentrations of dental hygienists, however, there are several other countries which have been training similar auxiliaries and producing a large number of graduates for some years. Japan, for instance, had fifteen schools for dental hygienists in 1959 - almost ten years ago and at that time 1,390 dental hygiene graduates were licensed to practice. Dental hygienists were established as a profession in Japan by the Dental Hygienist Law of 1948 and schools which were developed have programmes ranging from 1-2 years in length, although the final qualification does not vary from school to school.⁵

In 1954 India had four schools for dental hygienists and approximately 500 graduates. By the end of its fourth Five Year Plan (1970-71) they expect to be training about 4,500 dental hygienists annually.⁶ Other countries with training schools include

* Presented to the annual meeting to The Canadian Dental Hygienists' Association, Friday, June 28th, 1968, Vancouver, British Columbia.

Norway, Fiji and Nigeria; and, of course, several nations without training facilities are employing dental hygienists trained in other countries, for example, Switzerland and the Netherlands. So we can see by this brief account that dental hygienists are employed in developing countries such as India and Nigeria as well as in highly developed areas such as North America.

The number of dental hygiene graduates, the number of dental hygienists registered to practice, and the number practicing must of course be compared to the population figures and the dental health needs of the nation.

The most recent figures available - all within the last decade - show the number of dental hygienists per 100,000 population in the following countries:

United States	- 7.7 ⁷
Canada	- 1.9 ⁸
Britain	- 0.55 ⁹
Japan	- 1.5 ¹⁰

We can easily see that the United States has the best ratio. But where does Canada stand in relation to these other countries? Canada is shown to have a better ratio than Japan, however, these figures need some explanation. The Japanese figures, although slightly lower than the Canadian, were taken some eight years before the Canadian figures. Hence, we could expect the ratio for Japan to be better than Canada at a similar date. One added factor is the more favourable Japanese ratio of dentists to population.

The situation is somewhat different when comparing Britain and Canada. Canada had almost four times as many hygienists per 100,000 population as Britain. Although Britain's ratio of hygienists to population was lower there was a considerable number of the newly established Dental Auxiliaries practicing at this time who were not taken into account in this tabulation.

As we know, hygienists performing basically preventive measures are not the sole clinically trained auxiliary in the dental world. The dental nurse or auxiliary may have all or some of the following duties: the preparation and placing of restorations in the deciduous teeth of children; the extraction of deciduous teeth; the preparation and placing of restorations in permanent teeth, as well as the oral prophylaxis and other prevention measures. This auxiliary is another variation of assistance to the dental profession in the dental health care of the population. Referring again to Canada, we have the Dental Therapist in the Royal Canadian Dental Corps who places and finishes restorations on servicemen among other duties.^{11, 12, 13} In the United States there are several experimental projects using auxiliaries to perform part of the restorative procedures.^{14, 15}

New Zealand has been a true pioneer in this field, and since 1921 has been training school dental nurses whose restorative and preventive duties are restricted to school children. This country's experience with this type of auxiliary covers a period of almost fifty years in the course of which the programme has earned acceptance by the public and the profession.^{16, 17, 18} Several other South East Asian and African nations have followed New Zealand's lead and developed dental nursing programmes, for example, Malaysia and Ceylon. These are not small programmes, as illustrated by the fact that in 1964 Malaysia had two dental nursing schools and 283 graduates while Ceylon had one school and 132 graduates.^{19, 20}

At a more recent date than the New Zealand plan, Britain entered the picture. In 1960 an experimental training programme for dental auxiliaries was initiated at the New Cross General Hospital in London, England. The training of the auxiliary is similar to the New Zealand dental nurse except she is trained to work under the immediate supervision of a dentist and, consequently, is not permitted to make a diagnosis or treatment plan.^{21, 22, 23, 24} In contrast, the New Zealand dental nurse is supervised by a dental officer who inspects the clinics in his district at least three times a year.

The modifications of clinical dental auxiliary duties generally within each country depend greatly upon important local conditions. The lack of dental manpower, the lack of training schools and faculty combined with limited funds have influenced many developing countries to look to less expensive and more easily trainable auxiliaries who could support the existing dental personnel. The large number of dental personnel required necessitates efficient use of training facilities and financial resources.^{25, 26, 27, 28, 29}

In North America although we have a well developed body of dental personnel it is still not enough to meet the needs. These unmet dental health needs and the effects of less than optimum use of resources are not so apparent when viewed from urban private practice. Yet this is a situation which should not and must not be ignored.^{30, 31, 32}

At this point in my talk I will turn to the changing concepts of health care and their potential effect upon the future of dental hygiene.

Public health, as we know, means just that, the health of the public - the inclusion of all of the people, not only, as in dentistry, the one-third of the population which visit the dentist's office each year. The concept of total health care for all the population is becoming increasingly the demand of the taxpayers of our country. The dental health team, and we as part of it, are expected to provide the services demanded by the country. To ensure that we are able to meet the responsibility we too must look at our manpower, our training schools, our source of dental hygiene educators or faculty.³³

In this age of production efficiency there is an increasing need for auxiliary personnel in all of the professional disciplines. On the basis of experimentation and experience, royal commissions and other like bodies are finding that some duties may need to be further delegated in the future.³⁴ Such delegation would meet the objectives of providing service with reasonable expenditure of time and money. We only have to look at Medicine to see the effects of implementing this concept of delegation to their ever expanding number of support personnel.^{35, 36}

Today the public are taking a much greater interest and are more knowledgeable about health matters than in the past. They are asking questions about what is provided, how it is provided and is it being provided in the most efficient manner? Therefore, we must re-examine the evidence upon which our concepts and practices are based and if necessary be prepared to change them.

Consequently, the auxiliary profession of dental hygiene is coming into a very exciting period of its fifty year history. The whole field of dentistry, as well as all of the other health science professions, are being challenged as never before to provide adequate services to all the people of the nation. However, before we shall be able to solve the problems this challenge presents, there is a great deal of study and learning needed, and there must be a willingness to overcome rigid beliefs. One is the belief that because some duty has always been part of a particular occupation it should be, or that a certain combination of duties need be together.

When assessing our role as a dental hygienist or as a member of any other group in society we need to ask of our services several questions. And I use the word "services" not "ourselves" because we naturally tend to look at the situation from the wrong end of the telescope. It's not what we do, but the services we provide. Hence, the questions we ask of our services are as follows:

- What do they do for the people of the country?
- Are there better ways of providing the same services?
- Are these services even needed much less wanted?
- Would a redistribution of the same services with personnel in the field be more effective and efficient in providing the needed services?

and finally:

- Are these services reaching all the people who really need them?

It is good to be flexible and to be able to say - alright, we've assessed the situation and will go along with the suitable changes. But the success of the changes of the magnitude which challenge us today requires this very essential element of involvement, of active participation in the deliberations and first of all, actually recognizing the situations that may need to be changed. However, please do not misunderstand me. I am not advocating any particular changes. I am merely stating we need to be actively involved in ensuring that the public gets the services it requires and wants.

You may be familiar with the very apt quote attributed to John Stuart Mill and which appears in the front of Young and Striffer's book The Dentist, His Practice, and His Community. I quote:

"Great economic and social forces flow like a tide over half-conscious people. The wise are those who foresee the coming event and seek to shape their institutions and mold the thinking of the people in accordance with the most constructive change. The unwise are those who add nothing constructive to the process, either because of ignorance on the one hand or ignorant opposition on the other."

In summing up what has been said, I will go back to my initial phrases and say - let us look at the vital statistics of clinical dental auxiliaries around the world to see what experiments have been tried and in fact worked in their situation. Let us think honestly about what the public here in Canada wants today and for tomorrow and what we, after critical assessment, think we can provide.

The Canadian Dental Association is considering at this convention a Dental Health Plan for Children. Clinical auxiliaries - using this term in a very general sense - are an essential part of this programme. The source of needed dental manpower is an important factor in the implementation of the proposed plan.

As well as the Canadian Dental Association, the Department of National Health and Welfare has demonstrated its concern by the appointment of the Minister's ad hoc Committee on Dental Auxiliaries. I have a news release here which was produced by our Department and which describes the Committee's composition. Anyone who is interested may have a look at it after my talk.

If dental hygienists wish to influence the future of their profession, it is essential that they become actively concerned with the matters which I have brought to your attention. As a final consideration, the product of this concern and deliberation must be prepared in the form of a study or a brief that will be available for presentation when the opportunity presents to such a body as the ad hoc Committee on Dental Auxiliaries.

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BE GOOD TO EDUCATION... IT WAS GOOD TO YOU

During graduate training, each dental teacher has faced the same financial problems. Loss of income. The cost of education. Family living expenses. A move to a new city. Your donation could cut the edge off many of these expenses.

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COMMITTEE ON DENTAL AUXILIARIES FORMED

The formation of an ad hoc committee to study all aspects of dental auxiliaries was announced today by the Honourable Allan J. MacEachen, Minister of National Health and Welfare.

The committee was initiated by the Advisory Committee to the Minister on Dental Health and formed with the co-operation of the Canadian Dental Association. Members will study all aspects of dental auxiliaries, especially as to the possible contribution auxiliaries could make in helping achieve better dental health for Canadians.

This committee of multi-disciplinary memberships, both lay and professional, is involving in an organized way a level of knowledge and talent that has never before been concentrated on the major problem of finding solutions in this important component of the total health field.

The composition of the committee is as follows:

Chairman - the Honourable Dalton C. Wells, Chief Justice of the High Court of Ontario.

Four dentists representing private practice, nominated by the Canadian Dental Association - Dr. J.F. Reid, North Vancouver, British Columbia, Dr. M.A. Kamienski, Scarborough, Ontario, Dr. J.G. Belanger, Montreal, Quebec, and Dr. C.E. Dexter, Halifax, Nova Scotia.

One member representing dental education nominated by the Association of Canadian Faculties of Dentistry - Dr. C.W.B. McPhail, Assistant Dean, College of Dentistry, University of Saskatchewan, Saskatoon, Saskatchewan.

One member representing dental public health nominated by the Canadian Society of Public Health Dentists - Dr. Murray Hunt, Director, Division of Postgraduate Dental Education, Faculty of Dentistry, University of Toronto, Toronto, Ontario.

Nominated by Chief Justice D.C. Wells, one member representing the consumer - Mr. Cleve Kidd, Executive Vice-President, Canadian Air Line Pilots' Association, Montreal, Quebec.

One member representing the broad field of public health - Dr. G.D.W. Cameron, Peterborough, Ontario, formerly Deputy Minister of Health, Department of National Health and Welfare, and currently president of the Victorian Order of Nurses.

One member representing dental auxiliaries - Dr. Marjorie Jackson, Director, Division of Dental Hygiene, University of Toronto, Toronto, Ontario.

Ex officio member of the committee are Dr. J.N. Crawford, Deputy Minister of National Health and Dr. R.A. Connor, Chief of the Dental Health Division, Department of National Health and Welfare.

Additional members may be added if felt necessary.

An organizational meeting was held recently in Ottawa with the next meeting scheduled to take place on June 21.

Among other activities it is expected that the committee will be requesting briefs from various health and lay organizations, to assist in recommendations the committee may make regarding dental auxiliaries.

REPORT ON THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION BRIEF TO THE AD HOC COMMITTEE ON DENTAL AUXILIARIES

In June of 1968, the Department of National Health and Welfare of the federal government announced the establishment of an ad hoc committee to study all aspects of dental auxiliaries.

The Honorable Dalton C. Wells, Chief Justice of the High Court of Ontario was named chairman of the committee, which is composed of ten members representing private dental practice, dental education, public health, dental auxiliaries, and a lay member representing the consumer. In addition, two government representatives are ex-officio members of the committee.

Mrs. Shelley Altman, president of the Canadian Dental Hygienists' Association wrote to Justice Wells requesting that dental hygienists receive direct representation on the committee instead of being represented through the dentist who is to represent all dental auxiliaries. This request was not acknowledged, but in mid August Mrs. Altman received a letter requesting that the C.D.H.A. present a brief to the Committee. Mrs. Altman replied that the C.D.H.A. would be glad of such an opportunity, and appointed a committee to prepare such a brief.

Although it was necessary, because of the early date that the brief had to be submitted, to have this committee located in one city, opinions and comments were solicited from each member of the Board of Directors, the chairmen of the committees on Education and Recruitment and Manpower, Utilization, and Directors of Canadian Schools of Dental Hygiene. Although sometimes the lack of response was disappointing, several of these people were extremely conscientious and their comments were used extensively by the committee. The committee itself was composed of: Mrs. Shelley Altman, C.D.H.A. president, Miss Jill Downton, C.D.H.A. secretary, Mrs. Pat Kerr, president of the M.D.H.A., Mrs. Ruth Konzelman, Miss Louise Pollard, and Mrs. Margery Forgay, chairman.

The Brief was sent to Ottawa on October 17th. Limitations of space prohibit the reproduction of the entire Brief in the Journal, but the summary and recommendations are published below. Copies of the entire Brief have been sent to those who were asked to contribute to its preparation, and additional copies can be obtained by writing to the C.D.H.A. secretary, Miss J. Downton, 457 Winchester Street, Winnipeg 12.

SUMMARY AND RECOMMENDATIONS

It is almost axiomatic to say that the future will produce changes in the amount of dental services required by the Canadian people and the manner in which these services will be provided. Advances in research will even change to some extent the nature of those services themselves. There will be increased demand for dental care. There will be changes in the patterns of utilization of dental auxiliaries, in the functions delegated to auxiliaries, in the numbers of trained auxiliaries and therefore the number of formal training programs designed to provide them. There will be changes in distribution of dental services, likely with more participation by government. Different provinces may introduce differing legislation on these matters.

Some principles related to dentistry in Canada, however, must not change: high standards of competence and technical performance must be maintained, and the responsibility for services provided by the dentist and those auxiliaries under his supervision must remain with the dentist.

The Canadian Dental Hygienists' Association, being concerned with enabling Canadians to achieve the highest possible levels of dental health, therefore recommends:

1. That future efforts to improve the dental health of Canadians give high priority to the prevention of oral diseases. Any government program offering comprehensive dental services for children or any other population segment of significant size must concentrate its efforts in the area of prevention, not only for the sake of the optimum health of the group, but also for economic reasons.
2. That school boards implement preventive dental health programs utilizing hygienists within the school system as dental health educators as well as in the preventive clinical services.
3. That increasing numbers of preventive dental health programs be established by municipal, provincial, and federal public health agencies. Establishment of such programs should not be contingent upon government sponsored comprehensive dental health care programs, but would, of course, be absorbed by such programs when they are established.
4. That, in order to meet the problem of inadequate manpower in the area of restorative dentistry, dental hygienists receive instruction supplemental to the basic dental hygiene curriculum, which would enable them to perform simple restorations under supervision.
5. That hygienists thus trained, be employed both in private practice and government service.
6. That the basic qualification for dental hygienists remain the two-year diploma course, and that teaching additional functions to dental hygienists should not extend this basic program beyond two calendar years.
7. That where regional or provincial differences in dental hygiene function occur, or where functions are expanded, short courses be available to graduate hygienists which will enable them to keep abreast of these developments and encourage hygienists moving from one province to another to remain in the labor force.
8. That existing schools of dental hygiene in Canada be urged to increase their enrolment wherever possible.
9. That between eight and twelve schools of dental hygiene in addition to those presently contemplated, be established in the next fifteen years.
10. That, although the most favorable setting for a school of dental hygiene is within a faculty of dentistry, alternate settings ought to be utilized in order to educate adequate numbers of hygienists. These alternate settings include:
 - a) Universities without faculties of dentistry
 - b) Junior Colleges
11. That at least three programs at the bachelor's level be established for dental hygienists in Canada on a regional basis within the next five years, to provide personnel such as teachers and administrators for positions demanding qualifications above the diploma level.
12. That bursaries and scholarships be provided by all levels of government, by dental associations, dental hygiene associations and educational institutions to assist the pursuit of dental hygiene education at both the diploma and baccalaureate levels.
13. That dental auxiliary utilization programs be implemented and/or increased at the undergraduate dental school level and also at the post graduate level.

14. That restrictions on the number of hygienists permitted to be employed by dentists be removed.
15. That serial listing of dental hygiene functions be deleted from legislation.
16. That the term "direct" supervision of a dental hygienist by a dentist be modified to a description of what is considered to be adequate supervision.
17. That restrictions against the education and practice of male dental hygienists be removed.
18. That in those provinces requiring licencing examinations for dental hygienists, temporary licences should be issued to graduates of accredited schools of dental hygiene valid until the next scheduled examination period.
19. That the functions of the dental assistant and dental hygienist not be combined.
20. That dental assistants who have completed a recognized formal training program and have become certified be permitted to perform a wider range of services. The nature of these services should be related to increasing her efficiency as a chairside assistant working in direct cooperation with the dentist, (e.g. placing rubber dam) and not incorporate services which are performed as an independent clinical operator (e.g. prophylaxis).
21. That several additional formal day programs for training dental assistants be established.
22. That no individual should be permitted to assume or be assigned responsibilities to provide health services to the public unless he has achieved a standard of appropriate training or education which recognized authorities in the field consider to be an acceptable minimum.
23. That dental auxiliaries be duly represented on or have comprehensive consultation with any decision-making body whose deliberations will have a substantial effect on the auxiliaries concerned.

REMEMBER

The 6th Annual Convention,
July 10 and 11th, 1969,
Montreal, Quebec.

Your convention chairman is:
Mrs. Wendy Wilder,
200 Queenston Street,
Winnipeg 9, Manitoba.

Feel free to contact her about table
clinics, etc.

5th ANNUAL CONVENTION

CONVENTION DIARY VANCOUVER 1968

The National Convention of the Canadian Dental Hygienists' Association held in Vancouver, June 26-29, 1968 seemed greatly enjoyed by all who attended. Some 86 dental hygienists, including new graduates and directors of Dental Hygiene schools attended. Representatives of all provinces except Newfoundland were there. Several dental hygienists travelled from the western United States including the American Dental Hygienists' Association first Vice-President, Mrs. Lona Hulbush.

The opening evening of the program for the convention began with registration and happy reunions with former classmates. At the registration Thursday morning, program information and favours were presented to each registrant in a convenient shoulder bag. The surprises in each bag ranged from handcream to apple juice!

The first event of particular interest to dental hygienists was the panel discussion. Response was electric to the controversial subject of "duties of the dental hygienist". Because the surface of the subject seemed barely to have been scratched after two hours, members of the panel volunteered themselves for a resumption of the discussion the following day.

After luncheon at the Vancouver Hotel in the hygienists' Social Suite, a talk was given by Dr. Dennis Shalman, chief psychologist at the Burnaby Mental Health Centre. This provided a perspective on patient-dental personnel relationships from outside the profession.

For any spare time one could find, there were always discussions and displays open to the whole profession.

There was so much to see and talk about in the main convention area that the wine and cheese party Thursday afternoon in the President's Suite came as a welcome relief for most hygienists. This gracious suite was as comfortable and congenial as someone's home and thus lent a casual relaxed air to the activities there - whether socializing or intense discussion.

Friday morning's table clinics included several aspects of a career in dental hygiene and were well attended. The hygienists who participated in these clinics were kept so busy answering questions that some felt their well prepared slide-tape lectures were not as well regarded (and therefore not as useful) as they might be. Unfortunately for these same hygienists, the illustrated lecture by Dr. C.R. Castaldi of Winnipeg began before the clinic period ended. These hygienists then missed many of the recommendations he made for the oral health of very young children.

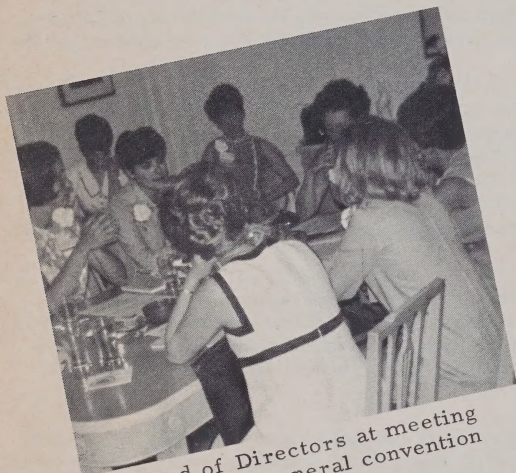
The luncheon break was prolonged Friday in order to allow for a most interesting diversion: a fashion show featuring uniforms - from traditional, white to mod, mauve. Little pots of flowers added some jaunty shapes and flowers to each luncheon place setting and the various draw prizes were a real treat - silver trays to uniforms!

At the Annual Meeting later the same afternoon, Miss Sharon Amer addressed the members and also answered the question foremost in most hygienists' minds: "What does your position of Senior Dental Hygienist involve?" At this meeting too, Dr. W. Munsie, then President of the C.D.A., formally acknowledged the presence of the dental hygienists at the convention and passed on greetings from the C.D.A.

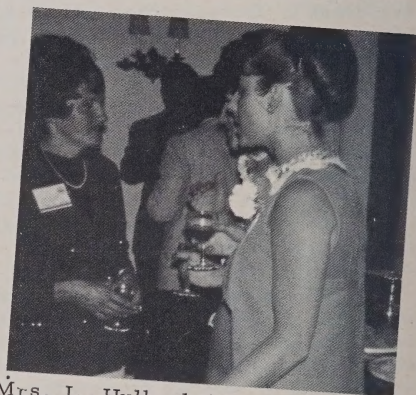
The evening in Chinatown was an exciting and eventful one. Chinese dinners were held in separate restaurants for hygienists and dentists. (This must have caused some confusion for hygienists married to dentists!) The hygienists' dinner included many different Chinese dishes that were very good.



Mrs. Jo Gardner (L) president
& Mrs. Carol Kline (convention
chairman) discuss the meeting



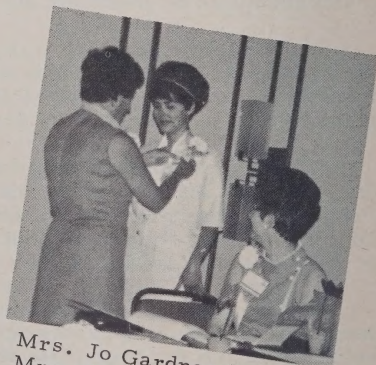
Board of Directors at meeting
previous to general convention



Mrs. L. Hulbush (L), 1st vice-
president, ADHA, talks with
Vancouver hostesses over cocktails



Fashions after Lunch



Mrs. Jo Gardner installs
Mrs. Shelly Altman as
1968-69 President

Following dinner, a parade was held down the main street of Chinatown and an exhibition with knives or swords took place. Then there was a fireworks display.

Everyone was then transported back to the Vancouver Hotel by buses thoughtfully provided by the dentists.

After the commendable displays put on by hygienists at the table clinics Saturday morning, Mrs. Lona Hulbush of the A.D.H.A. spoke on 'Dental Hygiene and the Changing Times'. She showed the film 'A Bright Future' which is available on loan from the A.D.H.A. and possibly the C.D.A. and O.D.H.A.

The convention then closed with a lovely buffet luncheon at the top of the Vancouver Hotel in the Panorama Roof from which hygienists reluctantly departed.

Appreciation for the enjoyment and knowledge obtained from this convention should be credited to the imagination and organizational ability of Mrs. Carol Kline and her able committee members.

PANEL DISCUSSION

The title of this discussion, 'Your Profession of Dental Hygiene', led many to expect another verbal portrayal of the present status of the hygienist. Instead, we were lead, under the able chairmanship of Dr. Ross Upton, Registrar of the College of Dental Surgeons of B.C., into a vital and animated discussion about the changing roles of auxiliary personnel. The core of the discussion was focused on the dental assistant -- her possible expansion of duties, changing responsibilities and future position in a dental office. More specifically, local changes were cited and the possibilities for a national change were discussed.

Where would the Dental Hygienist be left if the assistant were to begin intra-oral procedures? The panel suggested many possibilities, including public health, supervisory positions and educational appointments. She would be concerned only with the prevention of oral disease. The panel also pointed out that the Dental Hygienist would still find herself in great demand in the dental office. After all, who else can do heavy scaling as well?

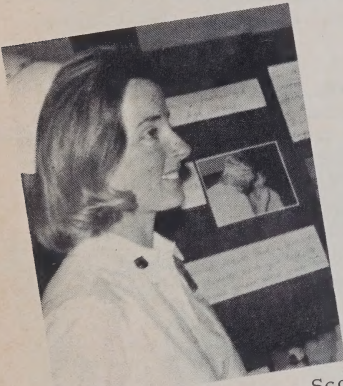
Although many hygienists present became perturbed, uneasy about their future, and even irate at the prospect of introducing a second auxiliary into an area already claimed by the dental hygienist, the discussion as a whole was very worthwhile. There was much food for thought here and it must be digested slowly. The members of the panel were able to impress upon the group that our cozy, impenetrable career is no longer so safe, and that there are changes in the wind. Not only that, but with foresight, tact, and understanding, the four panel members quite ably persuaded the hygienists present that the attitude to take should not be a small defensive one but a broad-minded, futuristic goal for the versatile, modern hygienist.

TABLE CLINICS

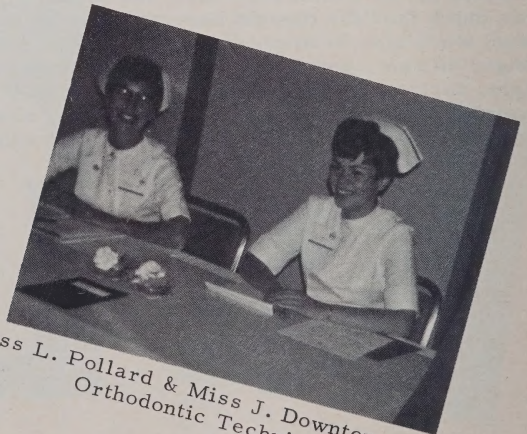
Dental Hygienists from across Canada presented various topics during the Friday morning and Saturday morning table clinics. The participants were:

1. "A Day in Public Health" - Mrs. Evelyn Peglar, R.D.H., Nova Scotia Dental Hygienists' Association.
2. "Orthodontic Techniques for the Dental Hygienist" - Miss Jill Downton, R.D.H. and Miss Louise Pollard, R.D.H., Manitoba Dental Hygienists' Association.
3. "The Ontario Hygienist" - Miss Leslie Harris, R.D.H., Miss Joan Hubbert, R.D.H.; Miss Ninfa Johnson, R.D.H.; and Miss Pat Brett, R.D.H., Ontario Dental Hygienists' Association.
4. "Doctor, Are You Helping to Recruit Hygienists?" - Miss Ruth Carter, R.D.H., British Columbia Dental Hygienists' Association.
5. "A Dental Hygienist in Your Practice?" - Miss Ruth Carter, R.D.H., and Miss Joan Sanders, R.D.H., British Columbia Dental Hygienists' Association.
6. "Keeping Smiles for the Future" - Dr. Alan S. Gray, Miss Irene Jordan, R.D.H., and Miss Donna Gunther, R.D.H., Okanagan Dental Health Team.
7. "The Hidden Truth" - Miss Sheila Hoople, R.D.H., University of Washington, Seattle, Washington.
8. "Oral Hygiene and the Handicapped" Alberta Dental Hygienists' Association. Miss A. MacIntosh, R.D.H., and Mrs. M. Wilson, R.D.H.

All the clinics were informative and colorful. Much preparation and thought had been put into the presentations and all the girls deserve a big thank-you for their efforts.



Mrs. E. Peglar - Nova Scotia
A Day in Public Health



Miss L. Pollard & Miss J. Downton - Man.
Orthodontic Techniques

CONTINUING EDUCATION COURSES

ONTARIO - UNIVERSITY OF TORONTO

January 20 and 21, 1969

Director: Dr. Marjorie Jackson

Enrolment limit: 20

Tuition fee: \$20.00

Lectures pertaining to recent advancements in the biological sciences, dental public health, fluorides and examination of the child and adult patient both clinically and radiographically will be given in this course for graduates in Dental Hygiene.

Discussions, demonstrations and student participation laboratories will be presented in Orthodontics and Dental Materials.

The course will be under the general direction of Dr. Marjorie Jackson.

To apply for registration, write for application forms to:

The Director,
Division of Postgraduate Dental Education,
Faculty of Dentistry,
University of Toronto,
Toronto, Ontario, Canada.

ALBERTA - UNIVERSITY OF ALBERTA

November 8 and 9, 1968

Director: Mrs. Margaret MacLean

Tuition fee: \$30.00

The course will include current research and trends in dental hygiene practice. Such areas as the latest research on calculus formation and control, instrumentation and instruments.

Discussion on the hygienist's responsibility in history taking and examination: prevention and control of gingival and periodontal problems and the latest practices for patient home care.

Limited registration.

As a result of enrolment limitations, applications should be submitted as early as possible to:

Division of Continuing Education,
Faculty of Dentistry,
The University of Alberta,
Edmonton, Alberta, Canada.

RECIPE FOR A CONVENTION -- 1969

As every woman knows, it takes many things to produce a good cake -- or a good convention -- and we think that we have them all!

Firstly you need a good recipe.

We've got it!

Our over-all plan for the convention is terrific.

Secondly you need quality ingredients.

We've got them!

Eloquent speakers, informative table clinics, visual aids à la Man and his World.

Thirdly, you need a good oven in which to bake.

We've got it!

The Queen Elizabeth accommodations and services are tops.

Fourthly you need a sense of timing.

We've got it!

Planned scientific program, plus free time at the fair, and theatre reservations.

Fifthly you need people who love cake and will eat it up (don't forget to brush).

We've got them!

380 C.D.H.A. members

See you July 10 and 11, 1969, in Montreal!

ASSOCIATION NEWS

C.D.H.A. MEMBERSHIP PINS

Birks, (Winnipeg, Manitoba) have issued a sketch of the proposed C.D.H.A. pin. The colours of enamel are lavender, yellow, and white. The size of the pin is approximately 1.5 centimeters by 1.5 centimeters. The cost of pin plus safety catch (10kt. yellow gold) is \$5.00 each.

A charge of \$40.00 has been absorbed by the C.D.H.A. to cover the cost involved in the preparation of an original die.

Delivery on orders will be approximately five to six weeks from the date of each firm order.

As instructed in the C.D.H.A. News Letter, each constituent association is requested to appoint a member who will submit a bulk order to:

Henry Birk & Sons Ltd.,
Portage Ave. at Smith Street,
Winnipeg, Manitoba.

Attention: Mr. R.J. Watson,
Insignia Dept.

Birks Winnipeg Branch will retain our original die. Remittance may be submitted either by cheque or by money order.

C.D.H.A. PRESIDENT'S PIN

There will be a distinct C.D.H.A. pin with attached miniature gavel (engraved PRESIDENT) presented to the active president and all past presidents of the C.D.H.A. The cost of these will be consumed by the Canadian Dental Hygienists' Association.

C.D.H.A. GAVEL

A gavel was purchased for the Canadian Dental Hygienists Association for the cost of \$9.75. The wrap around band plus engraving totalled \$10.43.

The engraving reads:

CANADIAN DENTAL HYGIENISTS ASSOCIATION

FOUNDED 1963

This gavel is now in the possession of our active president, Mrs. Shelly Altman, and will in future be passed on to each succeeding president.

THE C.D.H.A. LOAN FUND

A committee has been established to look into the feasibility of setting up a loan fund to which interested dental hygiene students may apply for financial aid. This fund will help to supplement the expenses of tuition and equipment needed by students enrolled in Canadian Schools of Dental Hygiene. Mrs. Evelyn Peglar from Halifax is serving as chairman. It is hoped that her committee will have completed their project so that this can be put into operation by the fall of 1969.

THE C.D.H.A. QUESTIONNAIRE

The Special Committee on Manpower and Utilization is attempting to prepare a questionnaire dealing with many aspects of dental hygiene. Some of the topics to be dealt with include numbers of hygienists, attrition rates, employment practices, and location of the hygienists.

It is hoped that the C.D.H.A. will be able to provide a beneficial service by having these facts on hand and by being able to present them to interested parties when called upon. The data should provide us with a current picture of dental hygiene in Canada.

NEW DENTAL HEALTH BOOKLET AVAILABLE

A new booklet on "Keep your teeth all your life" is available from the ADA. Prepared by the ADA Bureau of Dental Health Education, the booklet discusses periodontal diseases, caries, oral ulcerations and dentures. Copies may be obtained by writing the

ADA Order Department,
Headquarters Building,
211 Chicago Avenue,
Chicago, Illinois.

Prices are: 25 copies \$2; 50 copies \$3.25; 100 copies \$5.25;
500 copies \$24.94; and 1,000 copies \$47.25.

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Convention 1969	Mrs. Wendy Wilder	#601 - 1179 Grant Ave., Winnipeg 9, Man.
1970	Mrs. Karen Wise	#201 - 245 Wellington Cres., Winnipeg 9, Man.

NOVA SCOTIA

The Dental Health Committee purchased a set of career slides from A.D.H.A. The committee has written a series of six articles on dental health for the Junior Red Cross monthly magazine. They also wrote a play for primary children which was presented on a local television program.

For National Health Week, the committee did the following:

- 1) All outgoing mail from the Halifax Post Office was stamped with a Dental Health slogan.
- 2) Letters were sent to all city dental offices suggesting projects which could be undertaken.
- 3) An "Office Presentation Contest" was sponsored in the city dental offices. A plaque was awarded to the office with the best presentation. This year, the plaque was awarded to the Victoria General Dental Clinic.
- 4) Letters were also sent to every N.S.D.H.A. member in the province, regarding radio spot announcements to be submitted to local radio stations for use through National Health Week. As well, every radio station in Halifax was contacted and supplied with these spot announcements.
- 5) A poster contest was sponsored by the Halifax Dental Society, and was carried out in the city schools, up to grade six. The committee took part in judging the contest, and the chairman, Linda Wilson accompanied the three winners on "Firehouse Frolics".

MANITOBA

Manitoba hygienists will take part in the Winnipeg Santa Claus Parade this year. A float, sponsored by the Manitoba Dental Association, will convey "Christmas Greetings" to the public from the provincial dentists and from all dental auxiliaries. Two hygienists will represent the Manitoba Dental Hygienists Association on the float.

Dent



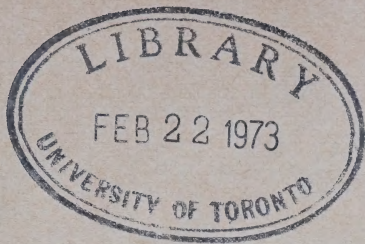
THE CANADIAN DENTAL HYGIENIST

SPRING
1969

VOL. III, NO. 1



Pelletier



THE CANADIAN DENTAL HYGIENIST

OFFICIAL PUBLICATION OF

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION

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TABLE OF CONTENTS

	Page
President's Message	7
Editorial Comment	9
Dental Care for Hemophiliacs	10
Dental Hygienists in Public Health; Nova Scotia	12
C.D.H.A. 6th Annual Convention	14
Establishment of a D.H. Placement Service	16
Auxiliaries Services Committee, C.D.A., A Report	23
Pacific Dental Conference, Dental Hygiene Program	27
Council on Education, C.D.A., A Report	29
Dental Dilemma: the Use and Training of Auxiliaries	32
Hygienists in Action	36
Book Reviews	39
Positions Available	41

INDEX TO ADVERTISERS

Ash Temple Limited	38
Block Drug Company	6
Columbia Dentoform Corporation	35
Dental Company of Canada	31
Dental Hygienists' Placement Service	35
Dentists' Supply Company of New York	8
Johnson and Johnson Limited	22
Medical Examination Publishing Company	3
Novocol Chemical Manufacturing Company	40
Pharmaco (Canada) Limited	4
Proctor and Gamble Company of Canada	5

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Dental Care for Hemophiliacs, page 10, Dr. Proctor discusses the specific problems of the hemophiliac child, and the special dental care they require.

Dental Hygienists in Public Health; Nova Scotia, page 12, another in our series of articles dealing with the duties of public health hygienists in different provinces of Canada.

C.D.H.A. 6th Annual Convention, page 14, Mrs. Wilder and her committee have arranged an excellent convention in Montreal, July 8-11. Plan your vacation there.

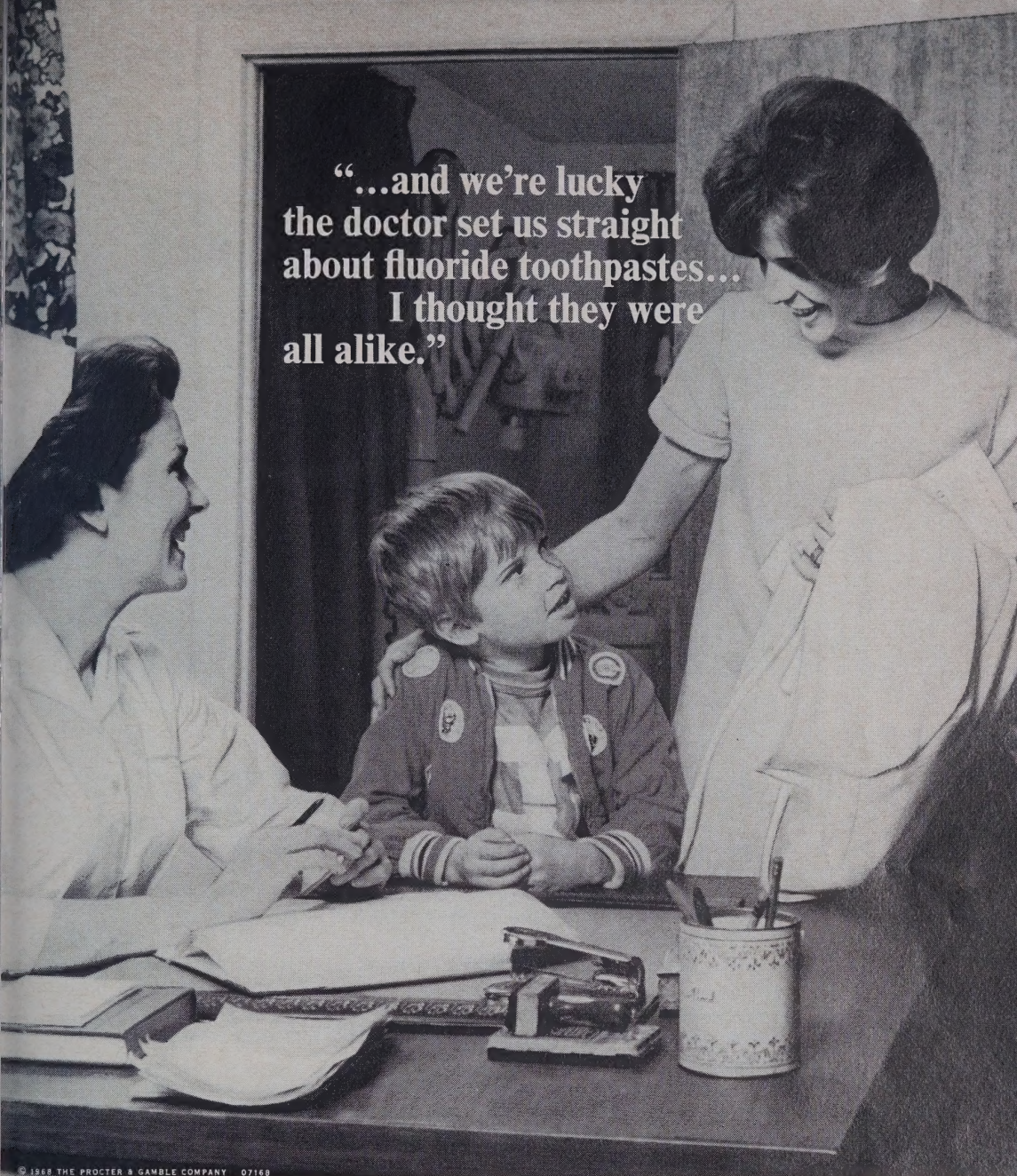
Establishment of a Placement Service, page 16, the O.D.H.A. has been operating a placement service for hygienists in Ontario since 1965. If your association is contemplating this type of service, the portrayal of the obstacles and the rewards will be very enlightening.

Dental Dilemma, page 32, Dr. J.W. Neilson, Winnipeg, and Dr. W. Gallagher, Seattle, took part in a symposium presented to B.C. hygienists and dentists on March 15th. Dr. Gallagher has some suggestions for the efficient utilization of dental auxiliaries.

MAILING ADDRESS

The C.D.H.A. will be using the C.D.A. office at 234 St. George Street, Toronto 5, Ontario, as its permanent mailing address.

This will commence April 1, 1969.



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PRESIDENT'S MESSAGE

Mrs. S. Altman, B.A., R.D.H.
President, C.D.H.A.

WHAT'S IN A WORD

What's in a word, you ask? Perhaps more than you realize. Words not only say things, they imply, suggest, implicate. Some words connote a whole visual image. Thus the choice of words can indeed be most significant.

When we think of the profession of Dental Hygiene, we associate ourselves with the dental health team, consisting of the dentist and dental auxiliaries. As you know the latter category consists of dental assistants, dental hygienists and dental technicians. With the ever increasing demand for dental services, new measures are being sought to increase the manpower supply. This has brought the area of dental auxiliary personnel into the forefront.

During the past year, the words 'dental auxiliaries' have been the focal point for several investigations. The Federal Government saw fit last spring to appoint the Wells Ad Hoc Committee to study the subject of dental auxiliaries. The C.D.H.A., having been asked to make a submission to the Committee, took the time to re-evaluate its thoughts on the future of auxiliaries. The results of the above happenings are not yet known. However, it is expected there will be some direct effects felt by us when the results are published.

Another occurrence in this area took place recently at a meeting of the Auxiliary Services Committee of the Canadian Dental Association. At this meeting, the validity of the term 'auxiliary' was questioned. Does the word really express the role that hygienists, assistants and technicians play in the dental field? It was suggested that 'auxiliary' implies a 'sub' level (second class); a reference to mechanical innate objects (motors) rather than expressing the human element.

I must admit that the thought never occurred to me prior to this discussion. However, after pondering over the issue, I began to believe that perhaps there was some merit in providing a new classification, a new image. After considering several alternate words, the Committee seemed to favor the term 'allied' personnel. This word connotes the team approach that we have tried so hard to promote. Allied suggests the 'whole' concept as opposed to the 'part' connotation of auxiliary.

You may wonder at this point if the entire subject is to be taken in a serious vein. Having thought the matter over, I do believe that it truly does. If we expect our profession of Dental Hygiene to make any progress, we must constantly try to improve ourselves. Just as a new hairdo enhances the appearance, the same may apply to a new name classification. If the new classification helps to enhance our image, and at the same time stands for the goal and ideals for which we strive, then I say press on. Out with the old, on with the new.

Whether or not the C.D.A. will change its terms of reference from auxiliary personnel to allied personnel remains to be seen. Now that the thought has been put forth, let us take time to consider it.

What's in a word, you ask? Maybe more than you realize. The auxiliaries of today may truly become the allies of tomorrow.

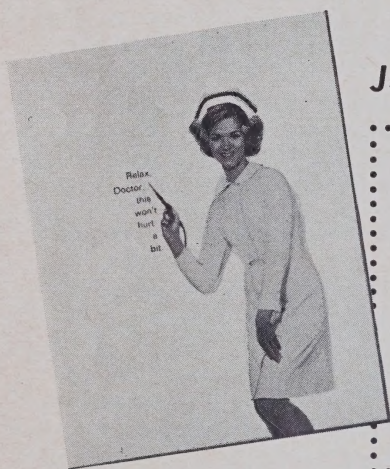
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EDITORIAL COMMENT

With the four walls of many dental offices in our country, there is an untapped potential -- the dental hygienist. Her potential for performance so far exceeds her present role that there is small wonder she complains of boredom, of being cramped by restrictive practice laws, of being smothered by an over-protective dentist who is afraid he may lose some 'status' to a pretty young girl. However, the blame for these feelings must not be placed on the dentists alone. Unless the hygienist asserts herself in some positive way to relieve her restrictions she should expect little in the way of assistance from others.

When dentists and hygienists talk about expansion of duties, it usually follows the lines of restorative dentistry. One area that is frequently overlooked is that of public relations. This is a field into which the hygienists can and should step with ease. She needs no further training; her education has prepared her for this role. Her knowledge of dentistry and her knowledge of the public and its reactions to dentistry, her rapport with her patients; all these things make her a natural person for this job.

Although we recognize that scaling and polishing teeth, exposing radiographs, and demonstrating toothbrushing techniques are the dental hygienists main function, a large part of her role should also encompass education and public relations. Education is public relations within the office (which daily manifests itself in a small way with greetings, farewells and short conversations at the chairside), and it should become community public relations as well.

To begin, how many people know what a dental hygienist is? The numbers are embarrassingly few, partly because of our small numbers, but partly because we spend a great deal of our time seeing the same informed persons over and over again. Ironically, these are not the people who need us most. The place where we may be most needed now is not within our four walls, but out among the populace.

The man who believes that periodic X-rays will render him sterile; the lady who thinks that 'pyhorrea' is an inevitable occurrence during middle age; the young parents who are sure that orthodontic treatment is only for those children whose wealthy parents want them to have a pretty smile; the teenager who is miserable with puberty gingivitis; these are the people that we should be reaching. This is public relations.

The dentist, working alone, can only begin to dent this wall of ignorance and fear. With our help the job can be accomplished much more quickly and perhaps more efficiently. Inform your dentist of your willingness to serve his patients in this capacity of public co-ordinator and prove to him your ability to do it well. As a group, contact your Department of National Health and Welfare, the local school board and the hospitals in the community. Offer to speak about dental health to groups of parents.

There may be little challenge to performing prophylaxis after prophylaxis, mixing fluoride solutions and ordering toothbrushes; but there is a challenge in public relations. To impart some of your knowledge, to give even a small percentage of the people you come in contact with the incentive to seek dental care; this can be very satisfying. The dental profession may be busier for our efforts; we may become better persons. Let us give more of ourselves.

DENTAL CARE FOR HEMOPHILIACS

D.B. Proctor, D.D.S.
Attending Staff, Winnipeg Children's Hospital
Attending Staff, Winnipeg General Hospital

INTRODUCTION

Hemophilia is one of a group of blood dyscrasias characterized by the absence of one of the factors that assist in blood coagulation, in this instance, Factor VIII or anti-hemophilic globulin.

As we will see shortly, the coagulation of blood involves a number of complex steps, and the lack of any of the factors involved in these steps may cause a breakdown in the coagulation mechanism.

The three conditions most commonly encountered in this group of blood dyscrasias are:

1. Hemophilia
2. Christmas Disease
3. Von Wildebrand's Disease

Hemophilia and Christmas Disease are essentially the same in character, except that different factors are missing. Von Wildebrand's Disease is caused by a lack of certain factors in the blood--with it the capillaries are very fragile and break down easily causing hemorrhage. This may be controlled relatively simply by means of continued pressure.

Hemophilia and Christmas Disease are hereditary sex linked diseases--that is the disease is transmitted by the female to the male. It is almost unheard for a female to have hemophilia--but she may transmit the disease. An interesting family tree is that of Queen Victoria, who was a carrier and as such transmitted the disease to the Spanish and Russian Royal Families.

BLOOD COAGULATION

As mentioned earlier, the coagulation of blood is a very complex mechanism. New discoveries are constantly being made as our knowledge and techniques are enlarged and improved. However, a fairly basic diagram of the procedure is shown in Table 1.

As shown in the diagram, when the tissue is injured, platelets are released. These combine with calcium and thromboplastin precursors to form thromboplastin. Prothrombin and accessory factors combine with this to produce thrombin, which in turn combines with fibrinogen to produce fibrin. The strands of fibrin then enmesh the red blood cells, to produce a blood clot.

TREATMENT

A. MEDICAL

Medical treatment is, of course dependent on the severity of the disease. Education of the patient and the parents is of prime importance. A knowledge of the severity of the condition, an awareness of the damer signs, knowing which activities to avoid and which to accentuate; all these play a large part in the control of hemophilia.

The standard method of treatment for years has been the use of plasma and whole blood by transfusion. To this, in recent years has been added steroids and cortico-steroids and latterly the use of anti-hemophilic globulin cryo-precipitates. The latter has been one of the more promising methods of treatment and is frequently used prophylactically--that is patients are having injections on a routine basis.

B. DENTAL

The most successful form of dental treatment of hemophilia is, as in all phases of dentistry, prevention. But here prevention has a somewhat more important role. The extraction of teeth for a hemophiliac can be a very risky business--given the injection of local anaesthetic should be avoided. Therefore prophylaxis, oral hygiene instruction, and topical fluoride application are of prime importance.

When extractions are necessary--and this is only when there is no alternative (e.g. endo)--the patient is usually hospitalized. He will be given a hematological examination, and not until the hematologist gives his clearance will the extraction proceed. Previous to admission, impressions have been taken and clear acrylic splints made. After the tooth or teeth have been extracted (usually under general anaesthesia) the socket is packed with a methyl-cellulose absorbable gauze soaked in thrombin. The splint is then put in place to protect the socket.

Another method of treatment that has met with some success is the use of hypnosis. It is particularly valuable in operative dentistry where local anaesthesia cannot be used. It has also been used to reduce and sometimes eliminate bleeding following extractions. There seems to be little scientific background for this success, but it undeniably does work in many cases.

HYGIENISTS AND HEMOPHILIACS

The real reason for this article is to give hygienists some understanding of the hemophiliac patient, and with this understanding the knowledge of how to treat these people. As stated before, the fields of prophylaxis, oral hygiene instruction and topical fluoride application, are of the utmost importance.

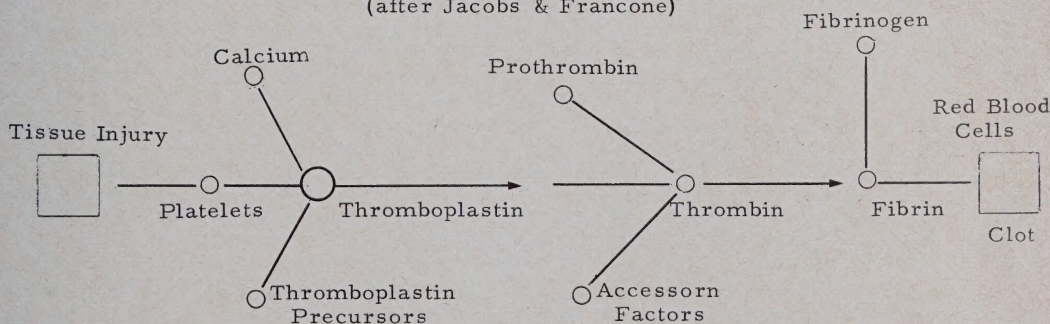
Sub-gingival scaling is important and must be done--and done carefully and gently. It is better to cause some minor gingival bleeding than to leave calculus to cause further irritation.

Do not use bristle brushes for polishing, as they are more liable to cause bleeding than rubber cups. In some areas where cryo precipitates are available, they will be given before hand, and will eliminate much of the concern re: gingival bleeding.

In conclusion, hygienists have a very important role to play in the dental care of hemophiliacs.

TABLE I

BLOOD COAGULATION (after Jacobs & Francone)



REFERENCES

1. Biggs & McFarlane: Human Blood Coagulation & Its Disorders, Oxford Blackwell Ltd. -- 1962
2. Biggs & McFarlane: Treatment of Hemophilia, Oxford Blackwell Ltd. -- 1966
3. Jacob & Francone: Structure & Function in Man, Philidelphia Saunders -- 1965

THE DENTAL HYGIENIST IN PUBLIC HEALTH: NOVA SCOTIA

Mrs. P. Marshall, R.D.H.

"Nine out of ten Canadians have had their health affected detrimentally by dental disease. So common is this affliction among the population that many accept it as an inevitable condition."*

Due to the close relationship which exists between the health of the mouth and the health of the whole body, the use of the teeth is greatly impaired by the presence of dental disease or irregularities of the teeth. To educate the masses and to overcome the apathy and misunderstandings which exist, we must do our utmost to make people aware of the relationship which does exist between good dental health and good health in general.

In the past, it was the policy to repair damage already done rather than do anything to prevent the disease. Now, however, the dental profession has come to realize that a reparative program is totally inadequate to cope with existing conditions. In order to maintain the healthy mouths with which children are born, authorities are beginning to focus their attention on prevention rather than cure. They see this as the best weapon against the disease.

It is thus in the field of prevention that the dental hygienist has a starring role. Speaking from the viewpoint of dental hygienists in Public Health, it is our primary objective to promote good teeth by prevention. In our field, we have two lines of attack - clinical and educational. Our efforts are channelled towards prevention both in our clinical fluoride program and also in our preventive dental health education program. As a dental hygienist working in Public Health in Nova Scotia, I shall try to outline our program.

The dental hygiene program was begun in the mid 1950's and has steadily changed to keep abreast of the latest advances in preventive dentistry. The hygienist is an integral part of the health team within the health unit. Along with the nutritionist and public health nurse, we are able to work more effectively by giving help and advice within our own fields of competence.

With our motto "Good Teeth Promote Good Health" we carry on our program of prevention. Our work is concentrated mostly in the elementary school. We are able to reach the children at an early age when good dental health habits must be taught. We see children from the ages of three years to grade six inclusive. It is during this period that normal growth and development should be taking place. It is also during these years that the children most readily accept new ideas and practices.

To carry out her clinical duties each hygienist has a completely mobile dental unit which she sets up in each school. Any school, no matter how small, may apply for the services of the dental hygienist. Each hygienist has an itinerary made upon the basis of applications received from her specific area. We try to make regular annual visits to an area. In doing this, we have a basis for tabulating the effectiveness of the fluoride program as well as our educational efforts.

In the dental hygiene clinic, each child, with parental consent, is given a dental examination, prophylactic treatment, and topical fluoride treatment. At this time, we are able to win the confidence of the child and in so doing, set the stage for our educational program by actually showing the child the importance of a dental prophylaxis as a valuable aid in the maintenance of good dental health. As education, to be of value,

* Your Child and Mine - Ontario Dept. Public Health

must be a direct and meaningful experience, we find this face to face relationship of the dental prophylaxis the direct approach which we need most. For seventy-five percent of the children, our services are their first experience of this kind. Therefore, we have the responsibility of representing dentists and dental services in a pleasant way. We must be sure that the child forms positive attitudes towards dentists and their services. Each child who needs dental care is given a notice for his or her parents. It is disappointing but only a small majority of children receive the necessary dental treatment needed.

Our work with the preschool child is most challenging. In the majority of cases, this is a new experience for them and his or her attitudes are permanently influenced by this initial visit. Therefore, we have the task of making the visit a pleasant one. At the time of the preschool visit, we have an ideal opportunity to speak with the parent. We show the parent and the child the correct method of brushing, talk over diet, visiting the dentist, and other queries of the particular parent. This consultation with the parent is a perfect time to clear up some of the false ideas which some people have. Many people think that a fluoride treatment will prevent all dental decay. We have to instill upon them the importance of good home care along with the fluoride treatment in helping prevent decay. They must be impressed with the fact that fluoride is our greatest advance in preventive dentistry but still it is not a magic "cure all". It is most difficult to overcome some of the apathy and misunderstanding which does exist. We hope, though, by these consultations and by the use of pamphlets that some progress will be made towards the child's dental health. This approach is our only hope of ever rearing a dentally healthy adult population.

Although the scope of our clinical duties is limited by law, our dental education is boundless. In the classroom situation, we are able to impart some of our knowledge by gearing the information to coincide with the mental age of the child in that grade. By the use of slides, filmstrips, posters, etc., we further compliment the chairside talks which we had during the prophylactic treatment. Many of us are seeking the active participation of the children in projects related to dental health. Personally, I feel the children learn far more by research done by themselves rather than our trying to push preconceived ideas upon them. In the classroom, too, we have the cooperation of the teacher who tries to follow-up our teachings in the months intervening our visits.

Besides the day to day work in the schools, we are sometimes called upon to speak at Home and School, Career Days, and other adult groups. At these groups, we are usually asked to explain our work and what we are trying to achieve.

As the end of the school term usually makes it impossible to continue our school program, the hygienist then takes her services to the provincial sanatorium or one of our provincial hospitals. Our duties in these institutions are basically the same except for the age levels of the patients. We are able to gear our educational instructions to a more advanced adult level. Our association with these patients in the clinical situation makes it possible for us to contribute to their optimum general health. As these same patients return to their homes, we hope they take with them the knowledge which they have acquired, thus further contributing to the dental health of their own families and communities.

The challenge is great and the frustrations many in this noble profession. However, the responsibility of dental health education cannot be borne by us alone. An organized dental health education program can be successful only by the cooperation of all health workers, teachers, parents and children. It is only with cooperation from all levels that we can hope to control and prevent this disease which is still one of our most significant public health problems.

C.D.H.A. 6th ANNUAL CONVENTION, MONTREAL

The sixth annual Canadian Dental Hygienists' Association Convention will be held July 8-11, 1969, at the Queens Elizabeth Hotel in Montreal. Mrs. Frank (Shelly) Altman, president of the C.D.H.A., and Mrs. Samuel (Wendy) Wilder, convention chairman for the C.D.H.A., invite you to join them for four days of fun, learning and laughter. Further information may be obtained from Mrs. S. Wilder, 200 Queenston Street, Winnipeg 9, Manitoba.

Dental Hygienists' Program: Queen Elizabeth Hotel

Tuesday, July 8, 1969

1:00 Board of Directors' Meeting - first session
President's Suite

Wednesday, July 9, 1969

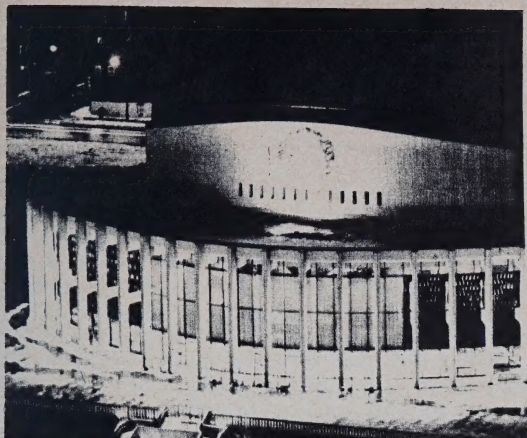
9:00 Board of Directors' Meeting - second session
President's Suite
7:00 Registration for C.D.H.A. Convention
President's Suite (Hospitality Suite)
Wine and Cheese tasting party for registering members -
Hospitality Suite

Thursday, July 10, 1969

8:00 Registration - Convention Floor
9:00-10:30 essay - Gatineau Room
Dr. Milton Dines, Montreal, Quebec
SPECIAL PROBLEMS IN DENTAL HYGIENE part I
10:30-12:00 Panel Discussion - Gatineau Room
The Future of Dental Auxiliaries in Canada
12:00-2:00 Luncheon - Gatineau Room
Guest speaker - Mrs. Patricia McLean, president of the
American Dental Hygienists' Association, New York, N.Y.
2:00 General Meeting of the Canadian Dental Hygienists' Association.
Gatineau Room
3:30 essay - Joliette Room
Communication and Motivation in Preventative Dentistry -
Mr. Cassidy - Montreal, Quebec
6:30 Board buses for Restaurant Hélène de Champlain
at St. Helen's Island.
An evening of fun at La Ronde and Man and His World

Friday, July 11, 1969

9:00-10:30 essay - Gatineau Room
Dr. A. Wainberg, Montreal, Quebec
SPECIAL PROBLEMS IN DENTAL HYGIENE, part II
10:30-12:00 free time
12:00-2:00 Luncheon - Gatineau Room
Installation of New Officers, C.D.H.A.
Presentations of C.D.H.A. Pins
2:00 table clinics
"The Ontario Dental Hygienist In Public Health and Hospitals"
Ontario Dental Hygienists' Association
"Home Care and the Periodontal Patient"
British Columbia Dental Hygienists' Association
"Dental Hygiene and the Handicapped Patient"
Manitoba Dental Hygienists' Association
4:00 Tour of Old Montreal - in luxurious air conditioned motor coaches
8:00 Reservations will be held in a block at the theatre



La Place des Arts.



*Ancient church spire
in Old Montréal.*

Registration Form - Montreal, Quebec

Canadian Dental Hygienists' Association Convention - July 8-11, 1969

	<u>pre-reg. June 1st</u>	<u>post-reg.</u>
Fees		
CDHA member	\$ 23.00	\$ 26.00
non CDHA member	25.00	28.00
Students		
Junior Member	\$5.00 per each meal attended	
American Visitor		
Husband or escort attending	\$5.00	
Man and His World evening and dinner		

Registration fee includes all Scheduled Social and Scientific Sessions
except Theatre, Friday evening, and La Ronde, Thursday evening

Miss, Mrs. CDHA member? Yes... No...

Address

.....

Total fee enclosed \$ _____ +exchange

Did you include \$5.00 for
husband or escort? Yes... No...

Payable to: Canadian Dental Hygienists' Association

Mail to: Mrs. Gary Hyman
#203 - 681 Sherbrook Street
Winnipeg 2, Manitoba

Hotel reservation deadline is June 1st. After this date we can not guarantee you a room. RESERVE SOON.

THE ESTABLISHMENT OF THE DENTAL HYGIENIST PLACEMENT SERVICE

Mrs. Pat Johnson, Supervisor,
The Dental Hygienist Placement Service (Ontario).

The establishment and operation of a placement service for the use of the dental and dental hygiene professions is an activity in which every provincial hygiene association will find itself involved. Indeed, it is an activity which every association must take steps to undertake, as soon as the need for such service becomes apparent. If dental hygienists are to consider themselves professional people, then there are certain responsibilities they must assume - responsibilities to their own profession, to the dental profession and to the public. One of the most minor of these is the provision of an organized, efficient means to place members in areas and positions where they are needed.

Indeed, I feel that a placement service of this nature is the responsibility of the dental hygienists' association, not of the dental association; it is a service well within our means and capabilities to provide. Many dental associations are willing to assist financially in the establishment of such a service, but responsibility for the service should rest in the hands of the hygienists. The existence of an efficient service provides a ready and tangible example of a dental hygiene association's maturity, capabilities, spirit of co-operativeness and interest in the general field of dentistry. The contacts established with the dental profession and the dental schools in the formation of such a service will prove invaluable when the dental hygienists' association seeks to obtain from the dental association and/or the legislative body greater representation and influence on all matters pertaining to dental hygiene. In other words, not only is this service our responsibility - it is an opportunity hygienists cannot afford to ignore.

Since 1964, I have been actively involved with Ontario's placement service. Using my past experience, in this article I will outline the procedure involved in setting up and maintaining said service and include any pitfalls we encountered, with suggestions on how to avoid the same.

History:

The first class of dental hygienists was graduated from the University of Toronto in 1953. There were only 6 in the class; graduates from the only Canadian school of dental hygiene in existence. Gradually the number of schools and students increased and by the early 1960's, the Ontario Dental Hygienists' Association acknowledged a need for some means of placing hygienists in positions available. We started by establishing an emergency roster for use of dentists whose hygienists were taken ill or were on vacation. A list of "retired" but available licensed hygienists was compiled from our membership and one "retired" member volunteered to receive inquiries at her home and to maintain the registry. This was only moderately successful since we had few retired members and most had full time commitments at home. This volunteer-run registry gradually undertook the placement of hygienists in permanent positions. This produced a heavier work load and results were not satisfactory. By 1965 (with 141 registered hygienists in Ontario), the O.D.H.A. executive recommended a placement service be established in a business-like manner with a full-time hygienist to supervise it. The School of Dental Hygiene at U. of T. now had capacity for 50 students in each year of the course; it was impossible for the Director to be responsible for handling all dentists' inquiries which came to her office and to find positions for all the students, plus past graduates and newcomers to the province.

Hence, in 1965, at the request of the O.D.H.A. and the Director of the dental hygiene school, the O.D.A. agreed to underwrite the expenses for the establishment of a placement service to handle the placing of graduating students and all other licensed hygienists. This service was to function as a business with a fee charged and a paid

supervisor, since the use of a voluntary supervisor had not proven successful as the work load increased. It was further agreed that a dental hygienist, cognizant of the needs of the dental and dental hygiene professions, should act as supervisor. The O.D.A., reserving the right to approve the choice of supervisor since they were making the financial investment, asked me to undertake the establishment and supervision of this service. The financial aid provided a typewriter, 2 metal filing cases, 2 years supply of application forms for dentists and hygienists, several years supply of plain bond paper (on which I typed a letterhead), envelopes, yellow manila copy paper, carbon paper and file folders. The O.D.A. also sent a letter to all members announcing the service and giving them my address and telephone number. The fee decided upon at this time was \$20.00 a placement (which soon proved to be insufficient to cover the time and effort involved and to provide for improved services).

Fees:

The introduction of a fee for the service was quickly justified. The dentists were reassured by the business-like procedures and expected to pay for satisfaction received. There was and is now no fee for registration; a fee is charged only after a hygienist is obtained. The establishment of the service demanded of the supervisor much time, effort and enthusiasm. Remuneration provided her with an incentive. Of the fee, the supervisor receives what is left after all expenses are paid. Whereas the volunteer was frustrated by the increasing number of inquiries, the supervisor who receives a portion of each fee is eager to handle each inquiry effectively. The most important result was the provision of the means to improve the service. Form letters could be sent to encourage retired hygienists back into the work force. It was soon found that a fee of \$20.00 left very little for promotion and other improvements. A later increase in the fee enabled the service to advertise in dental and dental hygiene journals and newsletters, to help alleviate the critical shortage of hygienists.

The Licensed Employment Agency:

After approximately a year of service, the Ontario Department of Labour informed us that the placement service required a license to operate an employment agency since we are charging a fee. By this time the advantages of the fee were recognized and we determined to continue with this policy. In an 8 month period, the placement service had handled 79 inquiries from dentists and 60 inquiries from hygienists so we were assured of the need to guarantee the continuance of the service. We then took steps to obtain a license. This took two years to resolve and the patience and help of the Department of Labour was appreciated. Assuming the provincial requirements for the licensing of employment agencies is similar across Canada, then our experience should prove particularly helpful in this area.

It was our feeling that the ideal repository of a dental hygiene employment agency was the provincial dental hygienists' association. However, in order to obtain a license the applying organization (O.D.H.A.) must be chartered. The O.D.H.A. is not. References which included the C.D.H.A. and the O.D.A. meant nothing. Chartering is a costly procedure and the professional organization seeking a charter must have in its membership 66% of registered members of the profession in this province. Ontario had 345 registered hygienists last year and we fell short of our required membership percentage.

Since the O.D.H.A. could not acquire its own license, we studied the merit of using another organization to achieve our object. This could be done in two ways - (a) let another organization, e.g. - O.D.A., take out the license in its name; (b) become a division of an existing licensed employment agency which would do the billing through its office. We declined the first proposal since we felt the placement service should remain entirely a dental hygiene effort and we appreciated the small degree of status it afforded the O.D.H.A. We declined the second proposal since we felt it would be unwise to associate our service with a more profit-oriented agency, engaged in a more encompassing commercial endeavour. Our service provided a specific need for the profession at a nominal fee and this was the principle we wished to maintain.

The only other route acceptable to the O.D.H.A. was the operation of the service under a license issued to a private individual. Surprisingly, the well recommended O.D.H.A. could not acquire a license but one was readily available to me. After ascertaining that my operation of a very low profit business would not jeopardize my husband's income tax and legal position to any great degree, I agreed to assume full responsibility for the placement service. A letter of agreement was drawn up between the association and myself, according to a lawyer's instructions. This meant that I had to provide the \$1,000.00 bond to the Ontario Department of Labour and also, the annual fee of one hundred dollars (\$100.00) for renewal of the license. Should any debts be incurred through the operation of this service, the O.D.H.A. is not liable - I am responsible. Should the O.D.H.A. obtain a charter in the future, I will not be required to relinquish to the association the operation of the placement service. However, if I decide to discontinue the operation of the service, the O.D.H.A. will have the first opportunity to assume the ownership. A license was issued a year ago and thus far, the results have appeared to be very satisfactory.

As a point of interest, all employment agencies licensed in Ontario must pay the same license fee of \$100.00. This means that I operating, with the interests of my profession at heart, a nominal fee service designed to fill a specific existing need, must pay as much as the large agencies that exist in all our cities. In order to cover my increased expenses (bond, license, advertising, etc.) and to have funds to initiate improvements in the service, it was necessary to increase the fee to \$50.00, payable by the dentist once he had hired a hygienist. If we had not guaranteed the continuity of this service, several large agencies outside the dental profession were ready to move into this field. They charge 8% of the annual salary or a fee of \$520.00 for a hygienist hired at a salary of \$6500.00 per year. Needless to say, the provision of a similar service for \$50.00 by the dental hygiene association is a real boon to the dentists.

Areas of Activity:

I function as a central information depot, keeping complete files on available positions and available hygienists. Hygienists are placed mainly in private practice, with fewer employed through the service in public health and in institutions such as hospitals.

The Dental Hygienist Placement Service provides hygienists (when available) for -

- (1) full time or part time permanent employment
- (2) temporary employment (summer)
- (3) emergency service (e.g.: illness)

Inquiries:

A file is opened for every inquiry. Full particulars are noted, all correspondence and copies of all my letters are attached, the date and context of all telephone calls are noted, names of all dentists or hygienists provided by me are noted, billing date and amount of fee entered.

Inquiries from Dentists:

I am contacted by letter or telephone. I will often enclose an information sheet with my reply to a written inquiry. However, I have found that many dentists would prefer to discuss their own particular needs personally over the phone rather than complete a general information sheet and I comply. Hence, either by telephone or by means of the information sheet I obtain the following information:

- 1) Date
- 2) Name
- 3) Office address and nearest main intersection
- 4) Residence address
- 5) Office and residence telephone numbers
- 6) Type of practice - general or specialty

- 7) Names, addressed and types of practices of any dentist(s) who will share the services of the dental hygienist.
- 8) Full time or part time employment offered. If part time, how many days per week?
- 9) Date position is available.
- 10) Have they previously employed a dental hygienist?
- 11) Would they be prepared to underwrite the expenses of a dental hygienist coming from out of town for an interview (where reasonable)?
- 12) Outline any further requirements and/or information they feel is pertinent.

I then contact hygienists, registered with the service, whose requirements and qualifications meet those of the dentists. The hygienist contacts the dentists and arranges, where possible, an interview. Hopefully, a placement will result. Whenever possible, I try to arrange several hygienist interviews for every dentist. Of course, availability of hygienists and location of practice influence this greatly. Whenever I receive an inquiry for a hygienist which I cannot fill immediately, I file the inquiry for future action and inform the dentist accordingly. At this time, I have 137 inquiries on file. I like to obtain the dentist's reaction to an interview in order to determine the qualifications he is seeking in a hygienist, thus enabling me to try and provide such a person.

Inquiries from Graduate Dental Hygienists:

As with the dentists, I may mail out an application form or note the information directly myself over the telephone. I will then provide the hygienist with as many names of prospective employers as possible (or reasonable) and she will contact them herself to arrange interviews. She will then report back to me on the success of the interviews. As with the dentists, I can then determine the type of position to refer her to in the future, if she has not found one to her satisfaction. The information I require from the hygienist is:

- 1) Date
- 2) Name
- 3) Address and telephone number
- 4) Home address and telephone number (if other than above)
- 5) Marital status
- 6) Birth date
- 7) Is she currently licensed to practice in the province in which she is seeking employment?
- 8) Dental hygiene school attended and year of graduation.
- 9) Experience as a dental hygienist (if none, please clarify). Provide names, addresses of employers, type of practice, and duration of employment with the dates involved.
- 10) If more than six months has elapsed since last position, please explain.
- 11) Preference as to type of practice in which she wishes to be employed.
- 12) Preference as to location.
- 13) Full time or part time (number of days) employment desired.
- 14) Date she can commence employment.

Inquiries from Dental Hygiene 2nd Year Students:

Shortly after the commencement of the Fall term, I arrange to talk with the members of the graduating class at the Faculty. The availability and operation of the placement service is explained. All students who need my assistance in finding employment after graduation complete an application form. This form is similar to the one for graduate hygienists except:

- 1) it deletes Nos. 7 and 10.
- 2) it rephrases No. 8 to read "date you expect to graduate".
- 3) it rephrases No. 9 to read "previous experience in a dental office".

For those students who are interested in employment outside Toronto (where the school of dental hygiene is located), I arrange interviews to be held during Christmas

holidays. This enables a student to take advantage of possibly being in that area (usually near her home) and alleviates further time and expense for her. Toronto dentists generally prefer to wait until closer to graduation before considering the employment of a student. We like to try and have the students placed in positions before they get involved in their final examinations. The shortage of hygienists, even for the Toronto area, has made this possible the past year or so. Naturally, the supervisor of a placement service has to be aware of any supplemental examinations to be written by a student placed through the service. Follow-up is necessary to determine if the employer is prepared to wait the necessary couple of months and to determine if the candidate successfully completes her year at that later date.

Advantages of Maintaining a Comprehensive Filing System:

- 1) Should, at a later date, a discussion arise over a part of the service provided, referral to the file will clarify the issue.
- 2) Ease in handling over a hundred different inquiries at one time.
- 3) Establishment of a well run, efficient business encourages trust and co-operation of individuals and agencies.
- 4) Provision of Statistics - one of the best sources of recent trends in dental hygiene. Such statistics as:
 - a) number of inquiries from dentists in particular areas.
 - b) areas in which dental hygienists seek employment.
 - c) number of hygienists in different age groups still in work force.
 - d) number of inquiries for hygienists from different age groups of dentists.

Book-keeping:

For income tax purposes, a complete record of all income and expenditures must be maintained. An ordinary exercise book will suffice. The front half is used to list in three columns, the date, names of dentists who have paid a fee, and amount received. Starting from the back of the book will be listed the date, amount and recipient of all disbursements. In order to claim the expenditures as operating expenses, receipts for every expenditure must be saved.

A statement, typed on a form available from a stationer or a printer, is mailed to an employer after a hygienist has been hired.

Advertising:

Once a placement service has been established, the next step is to inform the dental and dental hygiene professions of its existence. A form letter containing details of operation and fees (if applicable) is the easiest means. Most dental associations would be glad to print and mail such a letter as an informative service to their members. However, if this letter is included with several other general dental mailings, then many dentists set the entire contents aside as "just more literature". Just a point to remember.

Advertisements in journals and newsletters of the provincial dental association's, provincial dental hygiene association's and publications of corresponding national associations are helpful. Hoping to encourage hygienists to come to Ontario to alleviate our present shortage, I am arranging for advertisements in the publications of dental hygiene associations in the American states adjacent to Ontario. Advertising of this type requires much financing.

I also contact all hygienists who write to the R.C.D.S. in Ontario for information regarding licensure.

One form of advertising which has poor response is the classified ad in the "positions available" section of the local newspaper. It is better to ensure that all hygienists are aware of the service and approach you when they need assistance.

Promotions to Obtain Positions or Hygienists:

- 1) When a hygienist desires employment in an area where I have no leads, then a form letter is sent to every dentist listed in the R.C.D.S. registry for that area. This letter announces the availability of a hygienist for that region. Previously, I sent a letter to the secretary of the local dental society asking that he inform the members. Not one inquiry resulted from that method. The sending of form letters does provide a response and, although much more costly due to the printing and mailing, this is one of the improvements provided by the increased fee. A mailing to all dentists in Ontario runs to over \$200.00 for postage alone. The O.D.A. is most co-operative in this area.
- 2) Form letters are sent to hygienists who are listed in the R.C.D.S. registry as residing in the area where a dentist is seeking to employ a hygienist.
- 3) Form letters are sent to all hygienists registered in the province in order to reach those "retired" hygienists and encourage them back into the work force. A mailing of this nature costs \$20.00 in postage but is an important facet of the service.
- 4) Posting on the undergraduate hygienists' bulletin board of a list of areas where positions are available. Hopefully, we can encourage some students to consider positions away from the main metropolitan areas.

Salaries:

I make it a policy not to indicate what a dentist or hygienist is considering as a salary. I have found that many a dentist will pay more than he expected to obtain the "right" hygienist and many a hygienist will settle for less than originally stipulated in order to accept a particularly nice position. Prospective employers and employees have the opportunity to interview every possibility and then they can determine the salary.

However, the supervisor is in a position to become aware of the average salary range and can advise a dentist, hygienist or student who inquires.

Choice of Supervisor:

A dental hygienist who is retired provides an excellent choice, approved by both professions. She is cognizant of the requirements of the particular field. However, it is a responsible position with little outside control. The supervisor must be a self reliant individual, capable of organizing an efficient business. She must possess high standards as a professional person, be interested in people and be prepared to put her responsibility to the service high on her list of priorities. She should be keenly interested in the field of dentistry and dental hygiene. The supervisor must base all judgment in this regard on the best interests of the professions and not on personal gain or self interest. Enthusiasm, diligence and determination are prime requisites. Of utmost importance is the confidential nature of the work. The supervisor is not free to discuss inquiries, individuals or placements. I am not suggesting that I possess the above admirable qualities but, from my position of involvement, I can see that such attributes would be most desirable.

The supervisor should be available during the day to receive telephone calls. A business line, answered only during normal business hours, does not serve the best interests of the professions. Most telephone calls are placed at noon hour, during the hectic dinner preparation period and during and after the evening meal. These are the times when the dentist and/or hygienist are not occupied with patients and have the opportunity to talk in private, away from the office if need be. The previously mentioned remuneration does much to ease the inconvenience of having one's home telephone number available.

Business Address:

It would be wise to investigate the municipal by-laws in effect where the prospective supervisor resides. In my area, it is illegal to operate a business from one's home (not even piano lessons). The O.D.A. kindly permitted me to use their address as my mailing address. It appears on the letterhead and on the Department of Labour license.

The Human Rights Code:

The Dental Hygienist Placement Service has signed a Declaration of Equal Employment Opportunity. This affirms its support of the Ontario Human Rights Code and affirms its avowed intention to conduct all operations in accord with its provisions.

A Bond for the Issuance of an Employment Agency License:

A one thousand dollar (\$1,000.00) bond is required in Ontario, payable to the Department of Labour. It is returned if and when the agency does not renew its license and providing the bond or a portion thereof is not relinquished to cover a breach of the Employment Agencies Act. The total amount of the bond can be put up as cash. Another method is to "rent" a bond through an insurance agent. The fee for a \$1,000.00 bond is \$25.00 annually.

It took five years of diligent work to arrive at this present day service and, equally important, to guarantee its permanence and stability. I would suggest that an association which is presently working with fewer numbers of registered hygienists not be misled into establishing a short-sighted service which would fill current needs. Just as the number of hygienists in Ontario increased from 141 to 345 in only three years, so your numbers will likely increase rapidly. Take the time and effort now to establish an efficient organization which has the mechanism designed to expand functionally as the need arises. A nominal fee should be charged to enable the provision of the best service possible. The possession of a Department of Labour license indicates to the dentists the intent to operate a responsible service which is not functioning as a hobby for some slightly bored, house-bound hygienist. This service meets the stringent requirements of the government. A provincial dental association's support might very easily include provision of the annual license fee, if need be.

By outlining the steps of development of the existing service, other hygiene associations, who might follow similar lines of thinking, hopefully will be able to avoid some of our detours, obstacles and temporary measures. This article might prove useful as a guide. I would be very pleased to answer any specific requests for information. Close communication between individual agencies in order to ensure efficiency is to be encouraged.

The establishment of a placement service is both a responsibility and an opportunity for the hygiene association that decides to undertake it.

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— the most trusted name in surgical dressings —

AUXILIARIES SERVICES COMMITTEE, C.D.A., A REPORT

Mrs. Shelly Altman,
President, Canadian Dental Hygienists' Association

PREFACE

On March 10th and 11th in Toronto, the C.D.A. Auxiliary Services Committee met. The C.D.H.A. was asked to present a report, the text of which is printed below.

In addition, the C.D.H.A. was able to have recorded in the minutes the following:

1. The C.D.A. Auxiliary Services Committee will extend to all auxiliary groups an invitation to attend future meetings of this committee.
2. The C.D.A. Auxiliary Services Committee recognizes the existence of the dental clinician or therapist (Armed Services). (We were unable to get the committee to set up a group to investigate the future status of such persons in civilian life.)
3. Discussions on changing the term 'Auxiliary' to 'Allied'. This was to be presented as a recommendation to the C.D.A. Board in July. (Please refer to the president's message for further details.)

It was most gratifying to be in attendance at this meeting. The open discussions which occurred were most informative. I would stress that it is imperative that we continue to send representatives to such meetings. It is only in this way that our views will be aired most effectively.

TEXT OF ADDRESS, March 11, 1969

I am delighted to be in attendance here on behalf of the Canadian Dental Hygienists' Association. The majority of my remarks pertain to the "Brief on Dental Auxiliaries" as prepared by the C.D.H.A. and presented to the Wells Ad Hoc Committee on Dental Auxiliaries last November. Some of you have already seen the Brief and others will be looking at it for the first time. My intention is to condense some of the most pertinent of our recommendations and discuss them with you today. We feel that they offer some constructive suggestions for alleviating some of the problems existing in the dental health field.

Before going further, I would like to report that our association has tried this past year to provide more factual knowledge with regards to all aspects of Dental Hygiene. In this regard, we have at the present time an extensive questionnaire being prepared by our Manpower and Utilization Committee. This covers everything from the location of hygienists, types of employment, practice procedures, extent of duties, etc. Hopefully by the next meeting, the C.D.H.A. will have at its fingertips, the type of information that can be useful for those concerned with auxiliaries.

Our Education and Recruitment Committee is also in the midst of a fact finding mission to be completed by July. This deals with possible future sites for Schools of Dental Hygiene. This will be dealt with more fully later in my address.

To date there has been little work done in Canada in assessing the true facts re Dental Auxiliaries. We hope to make a beginning in this area.

The text of the Brief was intended to cover a variety of topics dealing with Dental Auxiliaries--with the main concern being in regards to Dental Hygienists and some references to Dental Assistants. The absence of references to Dental Technicians and other auxiliaries is not intended to imply a lack of importance to these but rather indicates the wish of the C.D.H.A. to comment on those areas in which it feels most qualified.

The C.D.H.A. recognizes the acute manpower shortage that exists with regards to providing dental services for the public. With the demand for services becoming greater each year and the prospect of government programs being established in the near future, it is imperative that measures be taken immediately to meet these demands.

In coping with the manpower shortage, there are basically three approaches one can take.

1. Educate enough dentists to meet the demand.
2. Increasing the productivity of dentists by maximizing the use of existing auxiliaries and by working longer hours.
3. Expanding the number and scope of existing dental auxiliaries. (1)

With regards to #1, while it is recognized that there is a need for the number of dentists to increase, it is doubtful that this will provide an ultimate solution to the manpower shortage. The main reason for this involves the high cost of educating the dentist (facilities, length of training, etc.)

With regards to #2, it is unlikely that increased hours even with the use of auxiliaries will make any appreciable difference in coping with the problem.

It would seem that the most promising prospects lie in the third proposal--the use of the present auxiliaries with emphasis on increasing their numbers and the scope of their duties.

We must also take into consideration that neither a program of mass prevention nor a program providing restorative work only, will cope with the demands. A program of combined preventive-operative procedures, each complimenting the other, is necessary. Since auxiliaries have been shown to be able to function in both these areas, it seems likely that they should be utilized in these programs.

The question then arises--Which auxiliaries should be involved and to what extent?

The C.D.H.A. is of the opinion that the present auxiliaries, the Dental Hygienist and the Dental Assistant, given broader duties combined with adequate numbers and their proper utilization, can best solve the existing dilemma.

This proposal is not a new one nor is it an "instant solution". However we feel that having considered all aspects of the problem, this may prove to be the approach which will have the best long term results. We believe that any program, must first face up to the problem; second, carefully weigh the evidence on all sides; third, procede with a view to the ultimate consequences. To ignore the future and those consequences arising from a given course of action, would be irresponsible and illogical.

I would now like to elaborate on our views regarding expanded duties. With regards to the hygienist, we feel that the very nature of her educational background makes her the logical candidate for the expansion of clinical duties. These duties may be dictated by regional demands. Such duties would be in the area of restorative dentistry, prosthetic dentistry, orthodontic dentistry, and any other area as would deem necessary. I would ask you to refer to resolutions #4 and #7 in the Brief. In our opinion, a diversity of function within a single auxiliary is preferable to a multiplicity of auxiliaries with narrowly restrictive functions. By allowing the hygienist to expand her clinical duties to a wider range will create an auxiliary which will best be able to adapt to future changes.

With regards to the dental assistant, I would ask you to refer to #20 in the resolutions. We encourage the assistant to preform a wider range of services;

"The nature of these services should be pointed to increasing her efficiency as a chairside assistant working in direct cooperation with the dentist, (e.g. placing rubber dam) and not incorporate services which are performed as an independent clinical operator (e.g. prophylaxis)."

The assistant is a valuable asset as the 'second pair of hands' and should remain in this capacity.

It should be noted again that neither auxiliary will be effective unless the numbers are drastically increased.

At present both the hygienist and the assistant provide valuable services within their own rites. We feel that to combine them into one auxiliary or to have them both performing in clinical areas would greatly defeat their usefulness. For example, by combining the hygienist and assistant into one would mean that at any given time, she could function as either one or the other, never both. This would seem to defeat the purpose of either auxiliary. Similarly, if the assistant were to perform services of a clinical nature, she would have to neglect those duties as the chairside assistant. This would leave a gap and possibly create the necessity for a third auxiliary, a new chairside assistant. We believe the solution does not lie in introducing more auxiliaries to perform fragmented services but rather to utilize those present more efficiently.

It has been argued that there are simply no hygienists to be had in some areas. This has lead to seeking alternate plane rather than recognizing the main issue and taking steps to alleviate it--i.e. by producing more of the present auxiliaries.

To re-iterate, it is our belief that the best solution to providing more manpower is to take the dental hygienist and the dental assistant, expand their duties within the boundaries as has been expounded upon above, increase their numbers and promote their more efficient utilization.

With regards to utilization, may I refer you to resolution #1 in the Brief which states,

"That dental auxiliary utilization programs be implemented and/or increased at the undergraduate dental school level and also at the post graduate level."

The C.D.H.A. has arrived at several constructive proposals which we feel merit consideration in providing increased numbers of auxiliaries. Basically these fall into three categories-- Education, Legislation, Implementation.

Education

At present the schools of Dental Hygiene in Canada are all located within a university setting housing a faculty of Dentistry. While this is considered the most ideal arrangement, the C.D.H.A. urges the consideration of other sites in the interest of providing more outlets for producing more hygienists. These sites could be within universities without Dental Faculties and within the Junior Colleges. (#10) This proposal is not to be taken as an alternate to the present system but in addition to the present system. Those schools so situated would function in cooperation with the nearest faculty of dentistry.

In addition the following points were noted. The number following indicates the proposal number in the Brief,

--the traditional two academic year program remain, and any additional duties that may be taught in future should not extend this program to longer than two calendar years. (6)

--At least eight to twelve schools of dental hygiene be established in the next fifteen years. (9)

--At least three programs at the baccalaureate level be established for dental hygienists on a regional basis to provide personnel for teaching, administration and research. This should occur within the next five years. (11)

--"Where regional or provincial differences in dental hygiene function occur, or where functions are expanded, short courses be available to graduates hygienists which will enable them to keep abreast of these developments and

encourage hygienists moving from one province to another to remain in the labor forces." (7)

--We encourage the establishment of more formal day programs in dental assisting. (21)

Legislation

In general, the C.D.H.A. urges more liberal and flexible legislation. It should allow for a wider range of duties, allow more flexibility in practice and decrease the need to constantly revise dental acts.

The C.D.H.A. urges consideration of the following:

--Deletion of serial listing. This to be replaced by;

"Recognition and permission should be given for hygienists to perform under supervision any function for which she has been trained in an accredited school of dental hygiene, and also such services as are 'of a minor nature and do not involve the exercise by the dental hygienist of the full professional skill or judgment required by (the licensed dentist)'."

--Deletion of the term direct supervision. This to be replaced by a "description of and a requirement for adequate supervision." (16)

--"That the restrictions on the number of hygienists permitted to be employed by dentists be removed." (14)

--"That restrictions against the education and practice of male hygienists be removed." (17)

--"In those provinces requiring licensing examinations for dental hygienists, temporary licenses should be issued to graduates of accredited schools of dental hygiene valid until the next scheduled examination period." (18)

--Consideration should be given to the status of the clinical technician from the Canadian Armed Services upon entry to civilian life.

Implementation

The C.D.H.A. urges all levels of government, federal, provincial, and municipal to take the necessary steps to introduce preventive dental health programs. (2), (3)

In the final analysis, the C.D.H.A. urges you to keep as the ultimate guideline, the thoughts in resolution #22;

"that no individual should be permitted to assume or be assigned responsibilities to provide health services to the public unless he has achieved a standard of appropriate training or education which recognized authorities in the field consider to be an acceptable minimum."

We would also refer you to the last resolution, #23, which requests a most pressing issue;

"that dental auxiliaries be duly represented on or have comprehensive consultation with any decision-making body whose deliberations will have a substantial effect on the auxiliaries concerned."

The C.D.H.A. cautions all bodies concerned with revision (both professional dental associations, provincial and federal legislators) to consider carefully all aspects of the problem before embarking on a course of action. It is in the best interests for all concerned (both the public and the professions) that ensuing legislation be guided by informed and rational thinking rather than by emotional or pressured thoughts.

A crisis has been reached today by the failure in the past to foresee future

problems and take up plans of action to prevent them. Today, in our desire to right previous omissions, let haste not be our guide but rather good judgment and rationale. An enormous task lies ahead ---- to provide the best possible of dental services for Canadians.

Consider carefully the responsibility. The future generations are depending on us.

PACIFIC DENTAL CONFERENCE, DENTAL HYGIENE PROGRAM

For the first time in Pacific Dental Conference history a special Convention program has been planned for dental hygienists! The four-day program, June 23 - 26, 1969 inclusive, features a unique vigorous scientific program designed specifically to meet the interests of dental hygienists, and a social program integrated with the social activities of the General Convention.

Five outstanding essayists headline the scientific program, and will present the most recent advances in the areas of dental health which pertain to dental hygiene. Recognizing that many guests will be attracted to the magnificent setting of Jasper, the social program has been designed to permit enjoyment of the surroundings.

It isn't too early to make plans to enjoy this Convention-vacation in the Alberta mountains. The one registration fee includes both social and scientific events: \$35.00 before April 30, 1969; \$40.00 after April 30, 1969.

Limited space has been reserved for accommodation for dental hygienists at Jasper's new apres-ski lodge, Lobstick Motor Lodge. The following daily rates will apply at the Lobstick during the Convention - Single \$15.00; Double \$17.50; Triple \$19.00. To ensure accommodation at the Lobstick please forward a deposit of \$17.00 to Miss Ann Macintosh, Accommodations Chairman, 9918 - 112 Street, Edmonton 10, Alberta. (Please make cheques payable to: Pacific Dental Conference, Dental Hygiene Section).

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DENTAL HYGIENE SECTION

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Registration Chairman,
12723 - 96 Street,
Edmonton, Alberta.

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Address: _____

Pre-registration fee of \$35.00 enclosed ☐

Date: _____

Signature _____

Dental Hygiene Program: Jasper Park Lodge

Sunday, June 22

Registration

Musicale

Monday, June 23

- 8:30 a.m. - Registration - Confederation Room
- 9:00 a.m. - Western Welcome Breakfast - Confederation Room
- 10:00 a.m. - Greetings and Opening Session - Confederation Room
- 11:00 a.m. - Scientific Lecture - Dr. R.A. Yuodelis -
"Modifications in Oral Hygiene Measures Required during
and after Complex Periodontal and Restorative Measures"
- Pyramid Room
- 12:15 p.m. - Luncheon and Fashion Parade - Confederation Room
- 2:00 p.m. - Table Clinics
- 6:30 p.m. - Barbeque by the Lakeside

Tuesday, June 24

- 9:00 a.m. - Scientific Lecture - Dr. S.P. Ramfjord -
"Biology of Periodontal Health"
- Pyramid Room
- 10:30 a.m. - Scientific Lecture - Dr. O.N. Lucas -
"Physiology of the Periodontal Tissue"
- Pyramid Room
- 12:15 p.m. - Luncheon - Confederation Room
Luncheon Speaker - Mr. Dave Pick, Jasper Park Naturalist
- 2:00 p.m. - Scientific Films
- 6:30 p.m. - Dinner
- 8:00 p.m. - Dancing - Edmonton Night

Wednesday, June 25

Local Tours, Scientific Films, Exhibits, and Wine Tasting Party

Thursday, June 26

- 9:00 a.m. - Scientific Lecture - Dr. P. Davidson -
"Psychological Methods of Reducing Pain"
- Pyramid Room
- 10:30 a.m. - Scientific Lecture - Dr. C.R. Castaldi -
"Modern Concept of Routine Dental Care for the Adolescent"
and
"Actualizing Preventive Dentistry"
- Pyramid Room
- 12:15 p.m. - Sherry and Farewell Luncheon - Confederation Room
- 6:30 p.m. - Dinner
- 8:00 p.m. - Dancing - Calgary Night

COUNCIL ON EDUCATION, C.D.A., A REPORT

Mrs. P. Johnson,
C.D.H.A. President-elect

The Council on Education extended an invitation to our President, Mrs. Shelly Altman, to attend two sessions of their annual meeting, held in Toronto February 5-7. As she was unable to attend, I took her place as your representative.

The Council on Education consists of the chairman, Dean Wesley Dunn of the University of Western Ontario, and four other members. Also present were the deans of all the dental faculties in Canada and representatives of other related dental organizations.

The C.D.H.A. was invited to attend two sessions:

- a) the first to consider guidelines for the training of dental hygienists. Also considered under the above topic was the resolution from the directors of dental hygiene schools in Canada.
- b) the second session involved discussion of a report entitled, "Minimum Requirements and a Mechanism for Accrediting Courses in Dental Assisting".

Guidelines for the Training of Dental Hygienists:

Dr. Paynter and his committee had prepared a report on this subject for the Council. Dr. Marjorie Jackson presented this very lengthy and extensive report in his absence. In general, it supported the suggestions outlined in the brief of the C.D.H.A. to the federal Ad Hoc Committee on Dental Auxiliaries.

Two sections which did not follow C.D.H.A. policy evoked much discussion. The first of these suggested that dental assistants receive improved training (supported by the C.D.H.A.) which would permit however the extension of their duties into the present field of duties of the dental hygienist. The second section suggested the reduction of the scope and hence, the length of training necessary to acquire a diploma in dental hygiene from a technical institute. The contention was that this diploma would result in more service oriented hygienists, as compared to the holders of present day, university acquired diplomas.

Council received the report with favour and agreed in principle with the following recommendations proposed by the committee:

- a) that there is a need for a limited number of degree programs for dental hygienists at the university level;
- b) that there is a continuing need for dental hygiene diploma programs at the university level; and
- c) that diploma programs in dental hygiene can be mounted in a non-university setting, provided that they meet the standards for accreditation as established by the Council on Education.

The report was then referred back to the committee for some revision with the request that the recommendations be consolidated and stated in precise terms for use in establishing new courses. The report in its revised form will be presented to the Council on Education next year and, if accepted, to the C.D.A. Board of Governors for action in 1970. At the C.D.A. 1969 annual meeting, the Board of Governors will be informed of the activities to date.

In the course of discussing the above mentioned report, I found it necessary to interject several times to present C.D.H.A. opinion as outlined in our brief. The

majority of those present who were familiar with our brief expressed praise over its content and form. Those who had not had an opportunity to see it were surprised at our progressive stand on the issues we undertook to study. I found many opportunities to comment and felt they were well received. Council members were attentive and I was aware of an increased interest on the part of the dentists as to what the dental hygienists had to say.

The resolution submitted by the directors of Canadian schools of dental hygiene was included in the agenda with the report on training of dental hygienists. This resolution urges the initiation of baccalaureate (degree) programs for dental hygienists. Included in the resolution are six areas of need for such personnel; specialized areas and not the general work force. C.D.H.A. policy is compatible with this resolution.

Dental Assisting Courses:

Consistent with C.D.H.A. interest in the field of dental assisting and our belief that better utilization of all dental auxiliaries is essential for improved dental services, I attended a second session of the Council on Education.

This session reviewed a report concerned with "Minimum Requirements and a Mechanism for Accrediting Courses in Dental Assisting". At this time, Council expressed reservations as to whether that body should be responsible for the accreditation of programs in dental assisting. They decided to discuss their concern with this matter with the CDNA and the CDA Auxiliary Services Committee.

If Council is requested to prepare a manual or set of guidelines bearing on the requirements of a program in dental assisting, then a reference committee will be appointed to prepare such manual using the pertinent sections of the above mentioned report as a guide.

If the Council on Education is established as the accrediting agency for sources in dental assisting, then that section of the report bearing on accreditation will be sent, as well, to the reference committee.

The reference committee will present the appropriate amended report to the next meeting of Council (February 1970).

It is to be hoped that some definite action can be instigated in 1970. The C.D.H.A. is on record as encouraging all efforts to establish training and educational facilities for dental assistants.

In conclusion, I appreciated the opportunity to attend this annual meeting of the Council on Education. It is very enlightening to one's thinking to participate in debate which includes varied opinions. I felt that the principles as outlined in our brief stood up well to this debate. Of course, not all of our recommendations were discussed at this meeting since it was not our brief which was presented. Rather, in discussion of the reports presented by the committees appointed by Council, I referred to the pertinent sections of our brief to substantiate the views I presented during the discussions.

I would suggest that every interested hygienist make it her responsibility to read the brief in its entirety, if possible. Certainly, the resolutions of the brief, printed in the Fall issue of the "Canadian Dental Hygienist" should be read.

Secondly I suggest that every hygienist refer to this brief in discussions with all levels of local, provincial and national dental associations. As an individual, the dental hygienist can promote interest in the brief with members of the dental profession, other members of the dental hygiene profession, and those concerned with the future of dentistry (public health, school boards, interested individuals, etc.). It is important that the C.D.H.A., through its members, continue to promote in the dental profession, a desire to learn the views of dental hygienists.

As the C.D.H.A. president-elect, the opportunity to attend both this meeting and the Auxiliary Services Committee meeting in March

- a) provided background in past developments and thinking of these committees;
- b) provided experience and exposure; and
- c) established liaison with individuals of the C.D.A. and the C.D.A. supporting employees.

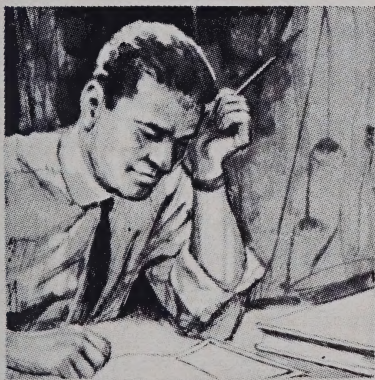
All of which should prove invaluable in my function as president next year.

C.D.H.A. APPOINTMENT

The position of Historian for the C.D.H.A. is to be filled by Mrs. Judy Wylie of Broadview, Saskatchewan. The executive extends to her their congratulations. If anyone has materials which pertain to the C.D.H.A. and are worthy of preserving (records, files, photos, reports, etc.) please forward with the details of each item to:

Mrs. J. Wylie,
C.D.H.A. Historian,
P.O. Box 10,
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DENTAL DILEMMA: THE USE AND TRAINING OF DENTAL AUXILIARIES*

The symposium held Saturday March 15 at University of British Columbia by the B.C.D.H.A. on Utilization of Dental Auxiliaries was attended by 33 dentists and dental students as well as members of the B.C.D.H.A. The session was most stimulating and informative. Previous to the symposium, neither Dr. Neilson nor Dr. Gallagher had much time to consult with the chairman, Dr. Claude Gardner as to the topic's significance in the present auxiliary situation in British Columbia. Both speeches, however, provoked many concerned questions from dentists in attendance.

The following is an excerpt from the presentation given by Dr. Gallagher. It contains suggestions directly pertinent to any employment and education situation of a dental hygienist.

The interest evident at the end of the symposium led a representative from the B.C.D.H.A. to suggest further symposia or briefing sessions with dentists interested in employing dental hygienists or in improving utilization of their own dental hygienists.

Before I comment on the use and development of auxiliaries, I would like to make a plea for the proper employment of them as co-workers on the dental team.

This thought conveys courtesy, respect and recognition of their services. They should be working with you and not for you. There must be good communication and rapport. Responsibilities and duties should be well defined. Good services should be recognized by thanks and increased pay and bonus.

The licensed dental hygienist has had a well formulated educational program.⁽¹⁾ The hygienist is educated to help prevent a variety of oral diseases and to participate in the treatment of periodontal disease. They are adept at making a preliminary examination and many are experts at securing radiographs. If dentistry is to approach its full potential, however, it must focus more precisely on prevention.

The following are recommendations for a full utilization of the hygienist with minor adaptation to the individual office.

1. She is primarily an oral health educator. She has the educational background in basic sciences and psychology to "motivate" patients in all preventive aspects of oral health care; tooth brushing, supplementary aids, denticator, floss stimulents, water flushing devices, diet counseling.
2. She should have 10-15 minutes time to educate each patient as to the preventive care on an individualized basis.
3. She should be given at least an hour to do scaling, root planing, curettage, calling these acts treatment instead of prophylaxis.
4. There are sufficiently varying conditions that she should be given the time to reappoint the patient a second or third time so that thorough scaling and planing is done if prevention is to be practiced to the fullest. This might also necessitate a recall appointment to check the effectiveness of the work and the patient's home care.
5. Her work does not have to be closely checked by the dentist. With each new patient, or when the dental hygienist is new, she should be introduced to the patient by the dentist and her role in prevention explained by the dentist.

* Excerpt from a symposium in which Dr. J. W. Neilson, periodontist and Dean of Dentistry, University of Manitoba, and Dr. W. Gallagher, Seattle periodontist, were the principal participants.

6. If the hygienist takes the X-rays she should process them right then, so retakes can be taken if necessary. This saves office and patient time in taking up another appointment for this.
7. She can explain the ways to the patient showing the pathologic changes in the mouth. She has the knowledge for this.
8. The dental hygienist is quite capable of examination and charting and should work closely with the dentist preparing things for him to do the treatment planning.
9. She is trained to take impressions for study models and should do this.
10. She should be given time to remove overhanging margins and polish fillings. She can be a separate "second pair of hands for the dentist".
11. She has the nutritional background to advise on diet where necessary and she should be given time to do this, or set up an appointment for this. She can give the patient diet sheets, take caries activity tests. She can explain the use of topical fluorides and fluoridation.
12. She should be in charge of the recall system in the office and should be given time when the dentist is not there to keep it up and running efficiently.
13. She can build a terrific practice on recalls alone. It would be best if she were employed on a full time basis.
14. She should be given all the benefits of vacation pay, sick leave, pension plan, social security and bonuses. This will make her a loyal and valued employee.
15. The dental hygienist by her education should be on the top of the graded auxiliaries as the other licensed personnel in the office, besides the dentist. The certificated dental assistant should be graded next; the casually trained assistant, the receptionist and office manager in a separate classification. The dental technician is in a separate category.
16. Each auxiliary should have specific duties and they should know them and be responsible so that the dental team is integrated.
17. Although she has her own chair and room, the dental hygienist should be an integrated member of the team and help in dental assisting should the need arise.
18. Auxiliaries should be trained along with the dental students including the dental hygienist so that the team approach is learned while in school.
19. The hygienist should have a "roving assistant" to assist her when the cavitron is used, to help her sterilize, seat patients and make future appointments.
20. Bi-weekly staff conferences of all auxiliaries should be set up on a planned basis—"bag lunches" with compulsory attendance so that the dentist can keep the auxiliaries integrated and foster the team spirit. Little problems should not become mountainous and loyalty should be engendered.

The duties of the dental assistant should differ from those of the dental (2) hygienist, although some overlapping is inevitable. If the responsibilities of the two auxiliaries are defined and are differentiated, then each auxiliary will have pride in her role and will tend to work cooperatively rather than competitively.

The Council of Dental Education of the American Dental Association has set up very definite guide lines for the education of the certified dental assistant and the certified dental hygienist. The minimum clock hours for the dental assistant is 1,000. The minimum clock hours for the hygienist is 1,850 with 1,950 to 2,000 as optimal. It is recognized that additional training provides a broad experience.

There are a variety of programs for dental hygiene teaching with different sponsorship such as a two-year program in a four-year college; a three-year program in a four-year college; and two to four years with dental school sponsorship. Generally, any time over the two years is usually occupied with general college courses toward a Bachelor of Science Degree.

The program at the University of Pittsburg⁽³⁾ described in the December, 1968 Journal of the American Dental Association, Vol. 77, #6, for dental assistants and dental hygienists would be a model for a dental school oriented program. The demonstration curriculum is organized around two sequential but interrelated phases: The first phase which can be the final one for assistants is a requisite for admission to the second phase, which leads to reception of a certificate in oral hygiene. Each phase consists of three terms of trimesters of 15 weeks each. In effect, although the curriculum is completed within a period of 22 calendar months, the program is longer than two academic years of traditional length.

As one contemplates the future practice of dentistry and the direction in which dental education should move in the years ahead, it seems most appropriate that the dental schools should seek to develop curricula, by 1970 at least, which will educate dentists who are much more periodontically and biologically oriented than today's graduates. The graduate of 1970 should possess many abilities similar to those of the best-trained periodontists of today. Only by a positive, significant change in the philosophy of dental education to some concept of this type can the dental schools break from the traditional pattern of dental teaching and prepare students to make fuller utilization of the basic sciences. At the same time, the goal suggested is one that is clear, one that has been achieved by some dentists, and one that probably would be acceptable to many. In fact, if tomorrow's students were able to choose, they would very likely prefer to be educated in this manner.

The impact of the acceptance of this philosophy upon the dental curriculum would be different in each school. In some, the changes would be drastic; in others, they would be solely organizational. Schools that teach a minimal amount of periodontics at present would face the greatest need for changes, and they might be confronted by problems that could be solved over a period of several years.

The concept that is being suggested would permit an interesting, integrated curriculum because it would become a frame of reference that would make parts of restorative dentistry more meaningful. If major emphasis were being placed upon the health of the supporting structures of the teeth, then the restorative procedures of operative dentistry, crown and bridge prosthesis, and partial denture prosthesis would take on new significance. Such procedures then would not be mechanical; they would be preventive. No longer would a particular type of cavity preparation or a choice of restorative material be a major consideration in itself; these things would be valued for their contributions to the total oral health of patients. Contours of restorations, fine cervical margins, and proper contacts would be contributions to the prevention of periodontal disease, not feats of technic.

-
- (1) Increasing Productivity and Reducing Disease.
The Dental Health Team: Potential role of auxiliaries.
W.E. Brown Jr., J.A.D.A., Vol. 75, #4, October 1967.
 - (2) Expanded Role of Dental Assistants.
Editorial, J.A.D.A., Vol. 73, #2, August 1966.
 - (3) Dental Assisting. Oral Hygiene Training. A. Model Program.
Forrest. Durocher Margart, J.A.D.A., Vol. 77, #6, Dec. 1968.

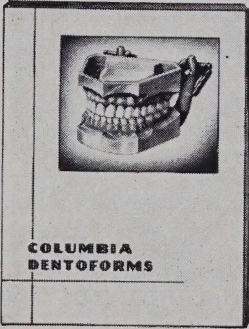
SATURDAY REVIEW ARTICLE CHARGES FLUORIDATION HARMFUL
TO KIDNEY PATIENTS

John Lear, science editor of Saturday Review magazine, has, for the third time in as many years, written an article criticizing fluoridation and raising questions about its safety. The latest article, appearing in the March issue of Saturday Review, charges that the use of fluoridated water in hemodialysis machines cripples and may even kill kidney patients. The article also suggests that drinking fluoridated water may be dangerous for any person with kidney disorders. The National Institute of Arthritis and Metabolic Diseases, which conducts a national research program on artificial kidneys, has commented that fluorides in water used for hemodialysis can be harmful, but so can other trace elements naturally present in water supplies. The Arthritis Institute has pointed out that hemodialysis units now routinely use deionized water, to remove not just fluoride elements from the water, but all other minerals as well.

William Stewart, M.D., surgeon general of the U.S. Public Health Service, has stated that: "Consumers of public water supplies enriched with minute quantities of fluoride in order to prevent tooth decay should not be misled by news articles which mention medical problems that may arise from using tap water in the artificial kidney. There is no relationship between the daily consumption of fluoridated water and the use of such water in artificial kidneys for the treatment of patients with total kidney failure." Both the PHS and the Arthritis Institute emphasize that the type of water used in hemodialysis has no relation to the ingestion of fluoridated water by anyone.

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*Mrs. Pat, Johnson,
8 Hallfield Road,
Islington, Ontario.
Area Code 416-621-8718*

HYGIENISTS IN ACTION

CHILDREN'S DENTAL HEALTH WEEK - February 1-9, 1969

The following is a summary of the activities connected with the promotion of Children's Dental Health Week in British Columbia, February 1-9. These activities were carried out by members of the B.C. Dental Hygienist's Association, the B.C. Dental Assistant's Association and first year Dental Hygiene students from the University of B.C.

1. Fourteen Kindergartens throughout Vancouver, North and West Vancouver, Burnaby and New Westminster were visited by hygienists, assistants and students who talked to the children on dental health and distributed toothbrushes, coloring books and pamphlets.
2. Eleven Libraries throughout Vancouver, North and West Vancouver, Burnaby and New Westminster were visited by hygienists, assistants and students who presented follow ups on the puppet show on dental health put on by members of the Vancouver Puppetry Guild.
3. The Vancouver Main Branch Library gave space on the children's floor to accommodate a display on dental health designed by dental hygienists Pat Hyba and Susan Lighthall.
4. The G.F. Strong Rehabilitation Centre for the handicapped was visited by hygienists and students who talked to the children about Dental Health and distributed milk and apples donated by the B.C. Dairies and Fruit Growers; by members of the Puppetry Guild who presented a play on Dental Health; by Mr. Harvey Lowe - World's Yo-Yo Champion.
5. Radio Advertising and Appearances
 - a.) 30-second spot announcements with messages pertaining to Children's Dental Health Week, were dispatched to B.C. radio stations.
 - b.) CJOR - Miss Hester Romberg and Marian Alexander appeared on the "Monty McFarlane Show".
- Dr. Margaret MacLean and Mrs. Bonnie Craig appeared on the "Jack Wasserman Show" for one hour.
 - c.) CKWX - Dr. G. Jinks and Miss Joan Sanders appeared on the "Bob Bye-Jim MacDonald Show".
6. Television Appearances
 - a.) Channel 8 - an hour long appearance on the "Jean Cannon Show" featuring Dr. G. Jinks, Miss Hester Rumberg and a Puppet play on Dental Health.
 - b.) Channel 8 - an appearance by the puppeteers promoting Dental Health on "Pete's Place", a morning children's show.
7. Newspapers
 - a.) The Vancouver Sun - a four column picture of Miss Hester Rumberg showing children from the G.F. Strong Rehabilitation Centre how to brush.
 - b.) The Vancouver Province - a picture of Miss Hester Rumberg showing a child patient how to brush.
8. Read-o-graph Signs

Children's Dental Health Week messages were sent to all read-O-graph outfits throughout the lower mainland.

In evaluating the success of this week, the Children's Dental Health Week Committee felt that those activities (the Kindergartens, Libraries and Rehabilitation Centre) involving the Dental Hygienists' time, imagination and initiative were the most effective. They felt that further co-operation with the Puppetry Guild in promoting Dental Health for the children in B.C. through the Libraries and Kindergartens (who were most receptive and eager for additional programs) and Elementary Schools (some having requested visits by the Hygienist and Puppeteers following the Week) on a year-round basis, would be most beneficial in public Dental Health Education.

They felt also, that the professional help given the Public Relations Committee for Children's Dental Health Week was not nearly as extensive and effective as in the previous year's. They felt that an investigation into the possibility of carrying out the same promotion without that help and concentrating funds to better use, is well worth instigating.

FIRST STUDY CLUB IN PERIODONTICS STARTED IN DENTAL HYGIENE*

The first known Study Club for registered dental hygienists was started by Miss Margaret Robinson, Director of Dental Hygiene at the University of British Columbia in February, 1969.

The Study Club is under the direction and supervision of two internationally known periodontists. Both of these specialists practice part-time in Vancouver, Canada, and commute two days a week to Seattle, Washington, U.S.A., where they teach graduate periodontics at the University of Washington School of Dentistry.

Twelve registered dental hygienists, some of whom are part-time instructors in Dental Hygiene at U.B.C., while others are practicing hygienists full time in the city of Vancouver, compose this newly organized group of professional women.

It may well be said that this study club has national and international implications in that the hygienists enrolled are from a cross-section of all the Canadian Dental Hygiene schools as well as a representative number from the northwestern states in the U.S. The Dental Hygiene schools represented are: Dalhousie University in Halifax; University of Toronto, in Toronto; University of Manitoba, in Winnipeg; University of Alberta, in Edmonton; the University of British Columbia, in Vancouver; the University of Washington, in Seattle; and the University of Oregon in Portland.

The intended goal of this Study Club is to enhance the role of the hygienist as a junior periodontist. It is hoped that it will expand her knowledge in more depth in the field of periodontics. Specific objectives are: more depth in histology and oral pathology, periodontal charting, deep scaling, curettage, root planing, pack placement and removal, and home care for periodontal patients.

The Study Club held its first session in February, 1969 in the Dental Hygiene Clinic at U.B.C., and will continue to be held every three to four weeks until early summer.

The desire of the hygienists presently involved is to make this a long-term study club. This however, will be determined by the periodontists involved and will be based on their evaluation as to the progress and motivations of the hygienists that are now participating.

* Margaret Robinson,
Director of Dental Hygiene, U.B.C.

CAPPING CEREMONY AT U.B.C.

The "first capping of dental hygiene students" took place at the University of British Columbia on March 13, 1969. This new program at U.B.C. started in September, 1968 with 20 students.

Dean Wah Leung of the Faculty of Dentistry was the guest speaker. He welcomed the dental hygienists into the profession and congratulated them in achieving their "caps" -- the first step in their professional education. Miss Margaret Robinson, the Director of the School spoke on the "meaning of the Cap"; and this was followed by the "Pinning on of the Cap" by two part-time clinical instructors, Mrs. Josephine Gardner and Miss Dorothy Mayers.

After the ceremony an informal tea was held in the Student Lounge with guests from the Dental Faculty, Staff and Student Body.

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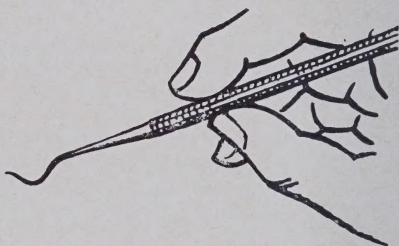
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PERIODONTICS FOR THE DENTAL HYGIENIST

By Don L. Allen, Walter T. McFall & Grover C. Hunter.
Philadelphia, Lea and Febrieger, 1968. 211 p. illus.
(Available from the Macmillan Company of Canada Limited,
Toronto) Price \$9.50.

This text focuses on the major aspects of periodontal disease which affect the work of a dental hygienist in the office of a general practitioner, or periodontist. There are outlines of anatomy, physiology, histology, and pathology of the periodontium (an adequate synopsis in these areas). Etiology is well covered with an excellent chapter which reviews periodontal pocket charting, and pocket recording and Instrumentation, with many good illustrations.

The last four chapters grasp the fundamental concept of the dental hygienist as patient educator, and emphasize the role she plays in all areas of periodontics—oral hygiene instruction, dietary analysis and counseling, visual education, laboratory tests, in the management of special patient problems, and in periodontal surgery.

Periodontal aspects are emphasized; for example, the section dealing with radiographic examination focuses totally on structure of bone and recognition of periodontitis to aid in the hygienist's charting.

This is a valuable text. It is recommended for the practising hygienist as a concise review, and for the senior student. Through it, she will achieve a broad perspective of her chosen field.

REVIEW OF DENTAL HYGIENE, Questions and Answers

By Pauline F. Steele.
Philadelphia, Lea and Febrieger, 1968. 322 p.
(Available from The Macmillan Company of Canada Limited,
Toronto) Price \$8.75.

This text provides, by question and answer method, a review by 14 well qualified contributors in their respective fields of study. Use of this book would be restricted to work already presented to the reader, and then accompanied by a reference text. There are no explanations, and few illustrations; the answers are given at the end of each chapter. An example of a question is:

The use of a chemical agent for disinfection of instruments is contraindicated when the patient on whom they are to be used gives a history of

- a. syphilis
- b. gonorrhea
- c. hepatitis
- d. subacute bacterial endocarditis

Knowing the answer here is one thing, but the "why" of the answer should be important to the reader. Hopefully, of course, the answer should stimulate the recall of the explanation. If it does not, **DIMENSIONS OF DENTAL HYGIENE**, also edited by Pauline F. Steele, is highly recommended for reference use.

The stated objective of the text is to provide "an authoritative source of review", and this it does very well. Much factual material is covered, and it is recommended to all students as an adjunct of study.

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11

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TABLE OF CONTENTS

President's Message	7
CDHA List of Officers	9
Report from the Editorial Committee	12
Message from the Membership Chairman	13
Report from The National Health Manpower Conference	14
A Day at Madigan General Hospital	16
CDHA 7th Annual Convention	18
Report on Unemployment Insurance	18
Report from the Montreal CDHA Convention	20
Report on the Panel Discussion at the Montreal CDHA Convention	21
University News	21
U.B.C. Reports	22
Continuing Education in Dental Hygiene	23
Review of Dental Research - 1968	24
Hypnosis - An Aid to Child Management	28
Report from the ADHA Annual Session	29
Positions Available	32

INDEX TO ADVERTISERS

Block Drug Company	6
Dental Company of Canada	11
Dentists' Supply Company of New York	31
Johnson and Johnson Limited	12
Medical Examination Publishing Company	3
Pharmaco (Canada) Limited	4
Proctor and Gamble Company of Canada	5

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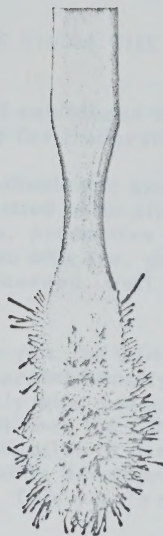
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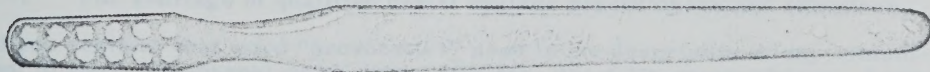
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MESSAGE FROM THE PRESIDENT

Honoured as I was by your vote of confidence in electing me as CDHA President, I also recognized the responsibility for leadership inherent in my acceptance.

Aided by a very competent and enthusiastic executive, Board of Directors and committee chairman, I am committed to an attempt to provide a provocative, far sighted, stimulating, progressive, productive year of activity. To expect this commitment from your association officers, you must be prepared to commit yourself to being a fully involved, concerned, well informed, decisive, contributing member.

The CDHA does not exist to serve you; the CDHA IS you! Enthusiastic, apathetic, responsible, neglectful, ethical, professionally immoral -- the CDHA is a reflection of its members and can be only what you and I want it to be. Six short years of excellent leadership have established the CDHA as a strong, respected voice for dental hygienists. We have an obligation to our previous officers to ensure the growth, improvement and responsible development of this association and of the entire dental hygiene profession. This year's officers have accepted this obligation -- HAVE YOU?

Heartened by that nationwide, enthusiastic response for commitment, I will now proceed to an outline of areas of immediate concern to us. These are the areas uppermost on my list and by no means indicate a complete tally. What topics would you add to this list? Write and tell us.

1. Maximum utilization of licensed dental hygienists.
2. Expanded functions for all dental auxiliaries.
3. Continuing education programs.
4. Refresher courses for retired hygienists who wish to return to practice.
5. Provincial dental hygiene legislation.
6. Membership recruitment.
7. Reciprocity between provincial licensing bodies for graduates of accredited Canadian schools of dental hygiene.
8. The advisability of establishing diploma courses in dental hygiene in post secondary institutions other than universities and how to maintain quality control.
9. The shortage of qualified dental hygiene practitioners and educators.

Did you register that word "provocative" used in the description of my commitment to you? An unusual word, some may say, but deliberately chosen. I see my responsibility as one of marshalling the forces of this association, stimulating effort and capturing imagination. The officers are not here to do your thinking and decision-making for you. We exist to encourage, to guide, to manage the affairs of the association, and to provoke you into thought and action; then to co-ordinate the results into a cohesive CDHA policy which is then presented as a strong national statement on your behalf.

May I suggest a course of action to begin immediately? Most of us have given a great deal of thought to many of the issues listed above. Do not let a time for thinking develop into a time for procrastination. Take each issue in turn and ask yourself what you as an individual and what your constituent and national associations have initiated as a means of resolving these issues. If the answer is nothing, then you make yourself responsible for taking some positive action. I would expect that a lot of our activities would involve others outside our own organization -- for research data, advice, etc.

An example of a line of questioning:

Does your association or do you have liaison with your district and/or provincial dental societies to promote maximum utilization -- e.g. a well organized, effective demonstration talk at one of their meetings?

Does the dental and/or dental hygiene school in your area conduct an effective course in utilization of dental hygienists?

Are you and every hygienist in your area aware of your responsibility as the profession's Preventive Control Therapists to convince and demonstrate to your own employers how to fully utilize your services? Let us not hear any more complaints about being bored performing prophys all day. If this applies to you, then you are not performing to the best of your abilities under existing legislation.

Apply this question and answer routine to all of the issues and then let the rest of us know, through related committees, newsletters and the Journal, what proposals you and your constituent members recommend.

"Organizations, like individuals, gain strength by accepting their responsibilities as well as by claiming their rights. Indeed, neither can be achieved without the other."

Author Unknown

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FROM THE EDITORIAL COMMITTEE

Greetings to all of our readers -- the undergraduate, the hygienist in private practice, public health, those of you working in hospitals, those teaching and those of you who are retired.

The Editorial Committee is striving to make this Journal your voice. The Journal is our common national link to share our views, news, events, scientific facts and experiences. This year each provincial association is to elect an editorial representative, whose job will be to forward Journal material to the Editorial Chairman. If your provincial association hasn't yet elected a representative please do this as soon as possible.

This issue and the May issue will be published in Vancouver. The closing date for receipt of Journal material will be the first week of the month preceding the issue month. Submitted material must be typed and forwarded to the Editorial Chairman.

Remember, we welcome your comments, views and submissions and look forward to hearing from you. Let us contribute provincially so that we can share Dental Hygiene news nationally.

Help us to help your Journal get out to all of you in full frequency, nationally communicating from coast to coast!!

Best wishes in all Dental Hygiene endeavours.

Editorial Chairman
Miss J.E. Dagg

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MESSAGE FROM THE MEMBERSHIP CHAIRMAN

... "Are you prepared, for example, to devote the necessary time and energies personally from your own busy day to the benefit of an organization of your fellow members, to attend meetings and serve on committees?"

... "Are you prepared to get out yourself and tell the public what is design, to speak to groups of all kinds and tell them what is design's role and function in society and what contributions professional designers can make, better than anyone else?"

... "Are you prepared to encourage young people to enter the profession . . .?"

... "Are you prepared to set aside, say \$200.00 to \$300.00 annually from your own pocket to set up and maintain a professional secretariat, staffed by an Executive Director who can speak authoritatively, day in and day out, on behalf of your organization?"

Substitute dental hygiene or hygienists in the appropriate spots in the above quotes from a digest of a recent talk by Robert A. Savage to the Interior Designers of Ontario, and ask yourself if you are prepared. Much is expected of professions not only in their acceptance of the responsibility to always act in the service of the public and in the public interest, but also to show that they are equally responsible in accepting the running and governing of its members through its own organization.

While we are not yet proposing a \$200.00 to \$300.00 membership fee, we are asking all of you to be a member, to work with your Association and for it and for the profession of Dental Hygiene. The benefits in the end come to you, the individual member.

Membership Chairman
Jo Gardner

To insure that you will receive all notices of meetings, conventions and your issues of the Canadian Dental Hygienists' Journal promptly, please keep the Membership Chairman of the Association informed of any changes in your name and/or address. The form below may be used to indicate such changes.

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Notify your Constituent Membership Chairman or send directly to:

Canadian Dental Hygienists' Association
Membership Chairman
234 St. George Street
Toronto 5, Ontario

NATIONAL HEALTH MANPOWER CONFERENCE

The CDHA was very fortunate to have received an invitation to attend this national conference, the first of its kind in Canada. It was called jointly by the Department of National Health and Welfare and the Association of Universities and Colleges of Canada for the purpose of developing a program for improving the human resources of Canada in the health and health related professions. The conference was held in Ottawa, October 7th to 10th.

The objective of the conference was to secure agreement on guidelines for planning the delivery of total health services during the next decade and for estimating the numbers and quality and for planning the education of the health manpower required for the delivery of these services.

Those participating represented consumer groups, government planners, professional associations, universities and colleges. Only 200 invitations were issued and, in view of the magnitude of the study, the dental hygiene profession, through our association, was fortunate to have been considered. Our inclusion in this conference is an excellent example of the importance of forming and maintaining a strong, well informed association. All hygienists should be aware of this conference and of the fact that, as individuals, we would not have been invited.

As President of the CDHA, I represented you. Also present were several members of the dental profession. The program was well organized and included excellent speakers from Canada and the U.S.A. who discussed:

1. Society's health expectations.
2. Planning the delivery of health services.
3. Planning to meet the needs for health manpower resources.
4. Educational trends and objectives.
5. Health manpower education - the challenge to educational institutions.
6. Co-ordination of university teaching programs for the health professions.

The program also included stimulating and thought-provoking panel discussions, followed by working group discussions. These group discussions were held in order to secure clear answers and agreements to several important questions in the field of health manpower, planning and education. These answers were presented in the form of specific recommendations for action by such agencies as the federal government, provincial governments, Association of Universities and Colleges of Canada, professional associations, consumer groups, etc.

If immediate solutions were expected from this conference, then disappointment was in store. However, further progress was achieved insofar as individual health disciplines came to recognize the existence, contributions and value of other disciplines and to think more continuously of total health care for the Canadian people. All speakers recognized the need for research into the conference topic -- more pilot studies and experimentation, etc. to determine goals of health care and personnel needed -- before positive solutions can be proposed. One topic which was given much time by the various speakers was the introduction of a core curriculum for related health sciences. This core curriculum would enable an individual to obtain full credit for any previous education within the core and allow for transfer to other fields or for further education with less repetition. One can see how core curriculum development will readily apply to dental hygienists.

A general report of the conference is to be published. It will include the major papers, background documents, and the final reports of the working group discussions. The recommendations of these group discussions will be submitted to a conference of the national and provincial health ministers in November. It is to be hoped that the health ministers will initiate necessary legislation and funding, thus enabling the conference recommendations to take effect.

The CDHA will publish the recommendations of the conference when this final report is issued. In the meantime, watch for results of the National Health Ministers' Conference in November. If action is proposed, then much activity should ensue on a local and provincial level. The executive will provide an outline of suggested methods of involving the dental hygiene profession in studies and meetings of interest and concern to ourselves; equally important, involving us in projects where dental hygiene can make positive contributions. It is not enough to want representation -- we must be able to offer co-operative and worthwhile service in order to merit such representation. We must be well informed about the members of our profession -- e.g. numbers, efficiency, utilization, education; about our community needs and how we may help resolve some of them; about activities of related professional organizations and government agencies which affect the community and ourselves; about the education of and facilities for providing future dental manpower -- anything related to our responsibility to dental hygiene, dentistry and the Canadian people.

To sum up, it is to be hoped that the recommendations of the National Health Manpower Conference will be studied and, where feasible, adopted by all organizations to whom they apply -- for the ultimate improvement of the total health of the people. There will be many direct and indirect results of this conference affecting dental hygiene and the CDHA. Our inclusion in the conference helped to establish us as a working entity with other health disciplines and government agencies. Future invitations to participate in planning our development are to be expected. Your president has gained an insight into the entire health care picture and can suggest means by which we can prepare ourselves to meet the challenge of helping to provide better care. At the conference we learned of several committees and agencies involved in studies which might be of concern to us -- requests for participation will likely ensue. As a young and active association, we have much to learn. The CDHA was fortunate to attend this conference and it is recommended that the Association avail itself of all such future opportunities.

President CDHA
Mrs. Pat Johnson

A DAY AT MADIGAN GENERAL HOSPITAL

On September 24, 1969, hygienists in British Columbia and the Northwestern States were invited to spend "A Day at Madigan General Hosital". This was sponsored by the Department of Dentistry, U.S. Army. The objectives of this conference were to emphasize the importance of the Dental Hygienists in the comprehensive care of the patient. The following are resumes of the four main speakers.

PREVENTIVE PROBLEMS IN "EVERY DAY DENTISTRY"

Lieutenant Colonel F.A. Karlson, Jr.

In the first century the world population was 250 million. By the 16th century, 1700 years later it was two times the above number. By the 20th century, the increase was fourteen times that of the 1st century, 3.5 billion.

From 1930 to 1960 it went from 2 billion to 3 billion in 30 years. Yet from 1960 to 1970, a ten year span it has already increased 1/2 billion. By 1980, another ten years it will increase by another 1 billion to 4-1/2 billion and by the year 2000 the world population will be 7-1/2 billion people.

Lieutenant Colonel Karlson stated that in the U.S. alone, that every day there is an increase in population equal to the population of cities the size of Tulsa, Oklahoma, or Dayton, Ohio, and this will continue from now until 2000.

He gave these figures to emphasize the problems of how to feed, clothe, dispose of waste, keep pure water, educate and provide medical and dental services to these increasing numbers. To be specific in regard to dental care to maintain the ratio of 1 dentist for every 1900 patients, they need 5830 graduating dentists each year. In 1966, 3200 graduated.

While Lieutenant Colonel Karlson came up with no pat answer as to how to meet this demand, he did feel that the role of the hygienists as a dental health educator both at the individual level and in the community should be stressed. He encouraged us to be enthusiastic, that through education, particularly of the young, to better dental health, the need for dental care in the adult can be reduced. He hoped we would assist the dental profession in preparing for the problems of tomorrow -- today.

BACTEREMIAS AND STERILIZATION IN DENTAL INSTRUMENTATION

Major R.D. Berringer

Major Berringer went quickly over the oral bacterial flora as a refresher for those attending. That it was a rather dense, stable bacterial population made up of alpha, beta, gamma, Group D streptococcus, Anaerobic streptococcus, lactobaccillus, leptospira and actinomyces. That bacteremias are the presence of organisms in the blood stream. The statistics Major Berringer quoted were rather interesting. In 50% of the patients you see and give a prophylaxis, you will cause a transient bacteremia. That in 25%, such a bacteremia can be caused by brushing and in 17%, it can happen from eating hard candy. He stressed that while these transient bacteremias are of a short duration, 10-15 minutes, they can cause disease particularly in the cardio-vascular system.

Before going on to the methods of sterilization he stressed the role the hygienist should play in insuring that an adequate medical history should be taken prior to dental work or scaling and polishing. He then continued with sterilization and disinfectant methods. That to achieve sterilization we must consider the number of organisms, the strength of the agent, the time in contact with the organisms, the temperature, the penetrating power of the agent and how tissue toxic the agent is. Major Berringer's preference was to scrub with phisohex, use an ultrasonic cleaner, then autoclave, remembering to autoclave pickup forceps as well, or the use of 70% Ethyl Alcohol for those that cannot be autoclaved.

DENTAL CALCULUS, PREVENTION OR REMOVAL

Major R.S. Schwartz

He felt nothing new in the removal of calculus has come about since the development of ultrasonics (Cavitron), and that the preventive methods that are used today are really inadequate. That while prevention of calculus formation, in theory is simple -- preventing plaque and mineralization of the plaque in actual practice is not so simple. Enzymes to date to prevent plaque formation are only experimental. This leaves the mechanical devices such as the toothbrush, stimulents, floss, water-piks, etc. which are all dependent on the patient and our ability to motivate the patient to use them to prevent plaque.

Because of this dependence on the patient, the dental profession and the hygienist are left with the problem of removal. We must realize the inadequacy and strive to find a more efficient answer.

THE DENTAL HYGIENIST'S ROLE IN THE TREATMENT OF ANUG

Lieutenant Colonel D.H. Newell

ANUG as Lieutenant Colonel Newell abbreviated it is rarely found in very young children and is rare above middle age. The dental profession used to think it was highly infectious and due to poor diet, poor oral hygiene and lowered resistance.. However, they found that many people had these predisposing factors yet did not have ANUG.

The treatment varied too. Glickman was instrumental in the use of hydrogen peroxide mouthwash until the patient's gingiva was less painful and then he would remove the deposits and polish the teeth. Fox felt you should scale immediately. It is now felt and borne out by studies in 1949 and again in 1953 that many patients were diagnosed as having ANUG when they had simple gingivitis or in some cases with high fever and malais they had acute viral infections, not ANUG. Further studies showed that it is not communicable.

Now the common basis for diagnosis of ANUG is profuse gingival bleeding ulcerating interdental papillae, marginal gingivitis, a temperature rise of no more than 1 degree F. and tension or anxiety.

In one study of 97 cases, 91 of these had a previous history of gingivitis, smoking had some correlation and it was tension related. The latter is of more importance than local facts.

The present accepted treatment is to start in immediately with the scaling to start the healing process as soon as possible. By just talking with the patient, find out what is bothering him to produce tension or anxiety. Lieutenant Colonel Newell felt that the hygienist was of great importance in this area. If necessary get the dentist to refer the patient to a social worker or psychiatrist and have them put on tranquilizers, rinse with warm salt water and cut down on the smoking.

Resume Submitted By
Mrs. Jo Gardner

We're tootin' an invitation to all hygienists!!

Come to a "Birthday Party" -- and what a party we're having. Manitoba is celebrating its 100th birthday, so come and join the fun at our 7th Annual Convention, July 1st to 4th in Winnipeg.

The West has a reputation for unequaled hospitality and Winnipeg hygienists have pledged to uphold this image. A wine and cheese party and concert, an evening of dining in a theatre restaurant, and a zangy wind-up party, are just some of our surprises.

Inspiring speakers, international clinicians, diversified table clinics, and an enlightening panel, plus fresh ideas and exchange of thinking are the aims of our planning committee.

Make plans for your summer vacation now! "Plan to be where the Action is". Everyone is coming to Manitoba in '70 even the Queen! Remember this is going to be the most exciting, inspiring, rewarding and stimulating convention EVER!

SEE YOU JULY 1st - 4th IN WINNIPEG.

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION

REPORT ON UNEMPLOYMENT INSURANCE, JULY, 1969

The question of payment of unemployment insurance by hygienists was first raised at the CDHA Annual Meeting in June, 1968. It was decided at that time that there was a need to investigate the question more fully to determine whether Canadian hygienists were in favour of paying unemployment insurance. As a result, a letter was sent to each of the constituent associations requesting information on different aspects of unemployment insurance payments. The replies indicated that hygienists were not in favour of contributing. Therefore, a letter was sent to the Director General, Unemployment Insurance Commission, presenting our views on unemployment insurance. The UIC was asked to reassess and re-evaluate dental hygiene as an insurable occupation.

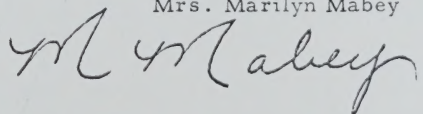
In his reply to the letter, Director General R.L. Beatty stated that the policy of the Government is to extend the coverage of the Act and to reduce the number of exceptions rather than add to them. He added that it would be unlikely that any recommendation for exclusion of dental hygienists would be acceptable.

All letters referred to in this report are on file with the CDHA President and/or Secretary. It is suggested that they be referred to when perusing this report.

Summary of Findings re: Unemployment Insurance Payments for Hygienists

1. There seems to be no set policy regarding hygienists, therefore it is suggested that a hygienist and her employer make a point of contacting the local UIC office to determine what their standing is.
2. It is the responsibility of the employer to collect and remit unemployment insurance payments, and to keep appropriate records. Failure to do this can result in a fine.
3. All employment in Canada under a contract of service is insurable unless it is listed as exempt in the regulations. This contract of service is a written or verbal agreement whereby one person agrees to work for another person under an employer and employee relationship. The worker is to do the work personally, under the direction and control of the employer, in return for some specific remuneration.
4. Conditions under which a hygienist is exempt:
 - a) If the hygienist's annual earnings do not exceed \$600.00, if she works less than 24 hours per week or less than twenty weeks per year. This is considered part-time employment.
 - b) A hygienist whose salary exceeds \$7,800 a year provided her rate of pay is other than by the hour, day, piece or other rate per unit of work. The hygienist would have to be paid on a weekly or monthly basis.
 - c) If the hygienist is paid by commission.
 - d) If a hygienist is employed by more than one employer and her employment under no one of such employers is that on which she is mainly dependent on her livelihood.
 - e) If the hygienist is employed under a contract for service. This point is very hazy and should be thoroughly investigated by the hygienist and the employer. It differs from the contract of service in regard to hygienists, in that they are contracted to come into an office to perform a prearranged service. The employer must be billed for these services. The deciding factor is whether this contract is of a continuous nature. There are special conditions which would exempt a hygienist under this clause but it is recommended that this be referred to a UIC office.

Submitted By:
Alberta Delegate, CDHA
Board of Directors
Mrs. Marilyn Mabey



REPORT FROM THE MONTREAL CDHA CONVENTION

Tuesday, July 8th was a day like all days, except it was also the first day of the CDHA Board of Directors' meeting, during the 1969 CDHA Convention held in Montreal at the Queen Elizabeth Hotel. This year was the first time that the CDHA found it necessary to have a one and a half day session before the annual scientific portion of the convention.

Wednesday evening registration and a wine and cheese tasting party started the social part of the meeting rolling. The Montreal hygienists at this time had their first chance to show us their hospitality. And hospitable they were!

Registration preceded Dr. Milton Dines' presentation Thursday morning as well. Dr. Dines, Thursday, and Dr. A. Wainberg, Friday morning, respectively, spoke to us on "Special Problems in Dental Hygiene". A panel discussion entitled "Current Developments Regarding the Dental Auxiliaries in Canada" sent blood pressures soaring at ten-thirty. Our special guest speaker, Mrs. Pat McLean, President of the American Dental Hygienists' Association was the highlight of our meeting. She spoke to us on Thursday at our luncheon, explaining the workings of her association. Following our Annual General CDHA Meeting in the afternoon, we boarded buses for an evening at the terrific "Man and His World". We had a great dinner at "Restaurant Helen de Champlain" and split up into groups to enjoy a few pavilions and travel on to La Ronde.

Friday morning was the beginning of another hectic day. Following Dr. Wainberg's address, we enjoyed a free period which most of us spent at Place Ville Marie. Our luncheon highlight was the presentation of past president pins and installation of new officers. Table Clinics took up a good part of the afternoon and at four o'clock we once again boarded buses. This time our open air "Golden Chariot" took us on a tour of the area. Needless to say this part of the convention was thoroughly enjoyed by everyone.

By this time delegates were thinking about catching trains and planes -- some to go home and some to go farther for some more fun and frolic. The 1969 CDHA Convention in Montreal was a success. My hard working committee, members being from Montreal and Winnipeg, were the ones to make this possible. So, until I see you all in Winnipeg for the 1970 Manitoba Centennial and the CDHA Convention, have a very good year.

Submitted By:
1969 CDHA Convention Committee
Chairman
(Mrs.) Wendy Wilder

REPORT ON THE PANEL DISCUSSION HELD DURING THE MONTREAL CONVENTION

The panel discussion held at our annual convention in Montreal was extremely interesting. Panelists representing an excellent cross-section of major Canadian issues affecting the dental hygienist were involved.

Moderator for the discussion was Mrs. M.G.E. Forgay, Director of School of Dental Hygiene at University of Manitoba. Dr. R.G. Romcke, Division of Dental Public Health, P.E.I. brought us information of the pilot project being done with hygienists filling and carving prepared tooth cavities.

Manitoba was involved this year in the preparation of a dental auxiliaries bill which would separate them from the Manitoba Dental Association. As President of our Association, I represented Manitoba on the panel.

Dr. K.J. Paynter, Dean, College of Dentistry, University of Saskatchewan brought us the latest information on the licenced Assistant-Hygienist in Saskatchewan.

Dr. B.P. Martinello, Department of Social Dentistry, Faculty of Dentistry, University of Western Ontario spoke on the plans for a degree program in dental hygiene to begin in 1970.

Dr. J.F. Reid, President of B.C.D.A. filled us in on the latest events of the two year training course for dental assistants in B.C.

A question and answer period followed the presentations. All in all, everyone felt that this was a successful event and definitely, one of the highlights of our convention!

Submitted By:
President, M.D.H.A.
Mrs. Karen Hyman

UNIVERSITY NEWS

DALHOUSIE UNIVERSITY, Halifax, N.S.

Dr. A.E. MacLeod was "acting" Director for the School during the 1968-69 term. In July, Miss Katherine MacDonald, formerly an instructor at Dalhousie, returned from Virginia to become Director. Mrs. E. Peglar is the full time instructor and Mrs. Deanna Silver and Mrs. Anne Mitchell are part-time staff.

This year, for the first time, first year applicants were limited to Maritime residents. The first year class numbers 20 and the second year class has 14 students.

UNIVERSITY OF ALBERTA, Edmonton, Alberta

In May 1969, 20 students graduated from the School of Dental Hygiene, University of Alberta.

The 1969-70 session commenced on September 2nd, 1969 with 26 students enrolled in first year and 23 students in second year.

Full-time appointments include: Mrs. Marga Pittman, Mrs. J.D. Karr, Dr. R.J. Dmytruk and Dr. J.H. Karr. The School is looking forward to its extended and expanded programs of study and research.

PROGRAM OF DENTAL HYGIENE AT THE UNIVERSITY OF BRITISH COLUMBIA

The Dental Hygiene Program at the University of British Columbia is now in its second year of operation. A total of thirty-five girls are now attending classes; sixteen in their first year and nineteen are preparing to graduate this spring.

The school is only a small part of the John Barfoot McDonald Building which will eventually accommodate 160 dental students. The building is an integral part of the proposed Health Sciences complex which as yet is incomplete.

The dental hygiene section is bright and modern -- containing twenty TRU-TORC and DEN-TAL-EZE units. Due in part to this modern equipment, the students are trained to do all procedures seated; with patients in prone and semi-prone positions.

All students must have one year of university in a science course before acceptance; and at present the majority of the girls are from the Vancouver area and surrounding districts, with one American student. Students in second year are rotated to other departments in the school one afternoon each week, and spend the four remaining afternoons in clinic. At present, they see two patients per clinic session and after Christmas will appoint on an hourly basis. First year students are nearing the end of their pre-clinical training and will take their first patients in January.

Dental hygiene staff is mainly part-time, with practising hygienists instructing one or two days each week. The exceptions are Miss M.M.E. Robinson (University of Oregon), Supervisor of the Program and Miss Marge Weich (U. of A.), Clinic Instructor. Part-time instructors include Miss Marion Alexander (U. of O.), Miss Stephanie Brawn (U. of A.), Mrs. June Coe (U. of A.), Miss Bonnie Craig (U. of M.), Mrs. Jo Gardner (U. of O.), Mrs. Alison Ridgway (U. of Wash.), Mrs. Susan Tick (U. of M.), and Mrs. Sandy Tucker (U. of M.). Because the instructors represent a cross-section of schools, the clinic techniques are a composite of their ideas, plus those of the students themselves. The result of this merging of thought is a distinctively unique school at U.B.C. Faculty-student rapport is excellent and the young program is now well established and operating smoothly.

Submitted By:
Class President
Miss Sharon Gray



CONTINUING EDUCATION IN DENTAL HYGIENE

THE UNIVERSITY OF MANITOBA

A one day session Saturday, March 14, 1970. The speaker for the day will be Dr. R. Johnson, D.D.S., M.S.D. His presentation will cover medical history taking, soft and hard tissue examination, clinical laboratory tests and soft tissue lesions. The session will be held at the Faculty of Dentistry, 780 Bannantyne Avenue, Winnipeg, and is open to all dental hygienists wishing to attend.

DENTAL AUXILIARIES' COURSES

Current Concepts and the Future
Potential for Dental Hygienists

Course No. 69-475 One Day Lecture and Demonstration

Instructor: Alexander Soberman, A.B., D.D.S., F.A.C.D.

Dr. Soberman is Assistant Professor of Periodontia and Oral Medicine, New York University, College of Dentistry; Attending and Chief, Oral Diagnosis Section, Department of Dentistry, Beth Israel Medical Center.

Synopsis:

This course is designed to acquaint dental hygienists with current thinking and progress in the following areas: caries control and fluorides, periodontal disease, prophylaxis, instrumentation (including ultrasonic devices), and home care.

The increasing prevalence of chronic diseases and the treatment of older patients present unique problems that may alter or modify treatment. These conditions are discussed.

Discussion of the future possibilities for the utilization of the hygienist for duties beyond which she is now trained.

Date: Friday, January 9, 1970

Place: Statler Hilton, 9:30 a.m. to 4:00 p.m.

Tuition: \$30.00 plus \$5.00 term registration fee for non-members of the First District Dental Society. Make cheques payable to First District Dental Society and mail to First District Dental Society, Statler Hilton Hotel, New York, N.Y. 10001, U.S.A.

1968 REVIEW OF DENTAL RESEARCH
PERTINENT TO THE DENTAL HYGIENIST

The following is an extract from JADA, Vol. 79, September 1969 reviewed by Doctor J. Christensen, D.D.S., M.S.D., Denver. Throughout the summary Dr. Christensen emphasizes the need and necessity of practising good preventive dentistry.

PREVENTIVE DENTISTRY

Dental Caries and Dental Plaque

Both dental caries and periodontal disease have been associated with dental plaque accumulation on teeth and in periodontal pockets. In spite of dentistry's insistence on toothbrushing little research has been published that deals directly with this subject in humans. A report on the relationship of cariostasis, oral hygiene, and past caries experience in children receiving three sprays annually with acidulated phosphate fluoride showed that over a three-year period "oral hygiene appeared to be related not only to caries incidence, but also to past caries experience". It was found that the lower the DMF surfaces, the more favourable the hygiene status observed over the duration of the study. The paper also demonstrated a 13% to 18% reduction in new DMF surfaces at the end of the three years. The fact that the teeth were not cleaned before application of the fluoride sprays appears to have reduced the effectiveness of the solution, but allows rapid delivery of this preventive service. Although plaque removal in animals has resulted in a reduction in dental caries, further human evaluation of oral physiotherapy methods and their effectiveness in plaque removal is needed.

Fluoride Treatment

Numerous methods to deliver fluoride to tooth surfaces were reported. The caries-inhibiting effect of daily applications of acidulated phosphate fluoride chewable tablets was studied for two years on 130 first, second and third graders. These children experienced a 20% to 23% reduction in permanent-tooth caries when compared with the 136 children in the control group. This method appears to be an easy way to apply fluoride to teeth. A longer evaluation of this form of administration would be desirable. A limited sample study of the fluoride content of teeth from children who drank fluoridated milk demonstrated that the fluoride ash content of these teeth was quite high and suggests that this may be an acceptable means for administering fluoride to teeth. Two separate clinical studies were published which used the fluoride compound, stannous hexafluorozirconate, for one-minute topical applications after a prophylaxis. Nine-month and one-year results showed that the new compound caused a dental caries reduction in DMFT and DMFS of 93% and 96%, and 81% and 76% respectively for the two studies. This compound caused more caries reduction than 8% stannous fluoride. In light of the high dental caries reduction reported, further studies for greater time periods are certainly indicated. The clinical effectiveness of stannous fluoride and acid phosphate fluoride as dental caries reducing agents in children was studied in 172 subjects. It showed that over a two-year period an 8% stannous fluoride or a 1.23% (pH2.8) acid phosphate fluoride solution reduced dental caries. However, the acid phosphate fluoride reduced dental caries more than the stannous fluoride. Apparently, the stannous or sodium controversy still exists, but since both agents reduce dental caries, personal clinical preferences can dictate the choice of solution. The clinical evaluation of stannous fluoride when used as a constituent of a compatible prophylactic paste (17.5%), as a topical solution (10%), and in a dentifrice (0.4%), in naval personnel, demonstrated that all agents reduced dental caries. However, the use of all three agents on the same subjects for two years resulted in the greatest dental caries reduction -- 70% of the subjects developed no new DMFT.

The ability of tooth structure to acquire and retain fluoride was investigated. It was shown that there is a delayed clearance of fluoride from the mouth for up to one week after topical treatment with fluoride or the use of a fluoride mouth-wash. This phenomenon was attributed to the prolonged leaching of fluoride from the teeth after its administration.

Repeated topical applications of acidulated phosphate fluoride gel in plastic mouthpieces to patients living in a community with fluoridated water revealed that on 121 exfoliated deciduous teeth, the fluoride concentration increased as the number of applications increased. The fluoride concentration was 1,785 ppm at a depth of 5 microns after an average of 56 treatments. No fluoride was shown at depths greater than 30 microns. This research is significant to preventive and restorative dentistry, when it is considered that 30+ microns can easily be removed from the surface of a tooth in finishing and polishing procedures.

The present knowledge of dental caries, preventive agents, nutrition and oral hygiene make the near elimination of dental caries within the reach of most motivated dentists and patients. The use of fluoride as a dental caries preventive agent is a proved mechanism, and its use in all accepted forms is encouraged. It is postulated that because of the current use of fluoride, adults in the future will have better teeth, and, therefore, better nutrition; stronger bone, and less osteoporosis; and possibly less hardening of the arteries.

Clinical effectiveness of phosphate-enriched breakfast cereals on the incidence of dental caries in adults was reported. Although the results were reported after only one year of experience, this unique method of administration in a non-fluoridated area produced caries incidence reductions of 42.3% in DMFT and 21.8% in DMFS. Further research is indicated on this subject.

Dextranase

A preliminary report of the effects of a dextranase preparation on plaque and caries in hamsters opened new avenues of caries research. A preparation containing dextranase derived from *Penicillium funiculosum* was continuously administered in the food or drinking water of hamsters that had been infected with cariogenic streptococci and maintained on a high-sucrose diet. These animals developed either less plaque than control animals or no plaque at all. Carious lesions did not develop on teeth which erupted after the treatment began. No adverse local or systemic effects were noted after 53 days of administration. Although this was an animal study, the significance of such dental caries reducing mechanisms, if applicable to humans, is obvious. Through the types of research mentioned, preventive dentistry will provide the key to the future.

RADIOGRAPHY

The use of panoramic radiography in dentistry is increasing because rapid surveys of oral radiographic conditions can be made easily. A report on 40 patients who had full panoramic (Panorex) radiographs, showed that intraoral radiographs are superior for the detection of anterior tooth lesions only, and that the taking and developing of panoramic radiographs required 10.38 minutes less time per patient. As clinicians have suspected, a comparison of bitewing and periapical radiographs for the diagnosis of caries illustrated that bitewings were superior for the diagnosis of primary dental caries, but that there was no difference between the two types of film for the diagnosis of secondary caries. A radiographic survey of 117 edentulous patients revealed that 17% of these patients had some pathologic condition, including broken roots, impacted teeth, radiolucent, and radiopaque areas.

Research and case reports on precancerous and cancerous oral lesions were reported in many journals. Two hundred forty-eight patients with oral leukoplakia were examined over a median observation period of 3.7 years. Eleven, or 4.4% of these showed malignant transformation. The overall experience with oral cancer in Connecticut from 1935 to 1959 involved 2,268 patients, of whom 973 had cancer of the tongue, 476 had lesions of the floor of the mouth, and 819 had lesions of the cheek, mucosa, palate or gingivae. Of these patients, 73.6% were men between 50 and 79 years of age. Most of the lesions were epidermoid carcinoma; in 56.3% the disease was localized at the time of diagnosis. Surgery was performed on 34.4%, 45.5% received radiation treatment, and 14.1% received a combination of treatments. The five-year survival rate was 41.7%. Several investigators and clinicians have studied the effectiveness of oral cytology. In 2, -52 oral lesions the reliability of biopsy in the diagnosis of cancer was 100% as compared to 85.4% for cytology.

PERIODONTICS

Prevalence of Periodontal Disease:

Periodontal disease in some form affects a majority of the population. A survey of human periodontal disease in Iceland revealed that nine out of ten Icelanders beyond age 4 have some form of periodontal disease.

Oral Hygiene:

Efforts to solve the plaque and calculus problem include studies of the electric toothbrush which was demonstrated to be more effective in preventing calculus in patients with periodontal disease than the manual brush. The major modes of attachment of calculus to root surfaces were found to be direct attachment of micro organisms or indirect attachment through a cuticle-like substance. Contributing modes included mechanical locking of calculus into planing grooves or dentin splits. Planing grooves can be made by any sharp instrument, and they were shown to be made also by ultrasonic instrumentation (Cavitron). A medium instrument setting and low pressure minimized the volume and depth of tooth structure removed.

Treatment Procedures:

A study of the value of subgingival curettage versus surgical elimination of pockets was accomplished on 44 patients with advanced periodontal disease. Conclusions were that there is an attachment of the supporting structures to the tooth after curettage, and that subgingival curettage in pockets deeper than 6 mm is followed by more favourable results than is the surgical elimination of pockets. A clinical and histologic study of repair sequences after gingivectomy demonstrated that 61% of the patients had epithelialization seven days after the gingivectomy. All patients showed epithelialization after two weeks. Inflammation recurred at the newly formed gingival margin. Gingivectomy on 17 patients increased tooth mobility nearly 20%. Electrosurgery was compared with periodontal knife surgery in dogs. Electrosurgery retarded repair and caused greater bone injury. Denudation of the alveolar process in humans resulted in severe and prolonged inflammation and the authors concluded that denuded bone would not be left exposed but should be covered with a soft-tissue flap. Repair after mucoperiosteal flap surgery in dogs was found to include some connective tissue repair as early as two days after surgery. Although alveolar crestal bone was resorbed slightly, the bone was recovered in one month. Close flap adaptation and coverage of bone lead to much faster and more uncomplicated healing than does apical repositioning, according to a study on four rhesus monkeys.

There are many remedies for the sensitivity of teeth after periodontal surgery. The desensitizing effect of a monofluorophosphate dentifrice was evaluated by twice a day use on 111 subjects. Placebo, 1.4% formalin, and 0.4% stannous fluoride dentifrices were compared to the monofluorophosphate dentifrice. All toothpastes, including the control, decreased sensitivity from 42% to 66% in four weeks. A comprehensive project testing all desensitizing agents would be valuable.

The topical treatment of necrotizing gingivitis with vancomycin hydrochloride ointment resulted in pronounced improvement within 24 hours and eventual disappearance of all signs and symptoms. Patients in the study could receive routine prophylaxis in 2.3 days. This technique offers a simple and advantageous treatment for a common problem.

Doctor Christensen is Professor and Chairman, Department of Rehabilitative Dentistry, University of Colorado, School of Dentistry, Denver, Colorado 80220.

"Just look there. Look hard, right at that thumb. And when you do, your eyes can just close, and you can just sleep like a rabbit under a tree."

Ridiculous though it may sound, it really works. It's hypnosis, and, after I recovered from my own amazement and skepticism, I discovered it is indeed a boon to dentistry and can save a hygienist much wear and tear, and many frustrating hours.

The situation in which I work demands that the dental team must often examine and treat large numbers of children in relatively short periods of time. This experience is trying for any children, especially for those of kindergarten age who have, in many cases, never received any dental care previously. Native children of this age are more difficult to treat than non-natives because of the lack of adequate communication and understanding, and consequent extreme apprehension.

In the past several weeks I have observed a behaviour pattern in these children which has made dental visits and treatment much more pleasant for everyone involved. It is that which results from hypnotic suggestion to the children prior to the actual treatment in our clinic.

Before beginning dental work for four classes of kindergarten, I went to the classrooms to do screening. After greeting the children and introducing myself as "the nurse who helps to look after your teeth", I explained what the dentist is and does, and told them that we play games when they go to the dentist. The game is "sleeping", and using a fixation technique, I put the group into a light hypnotic trance -- sleep; the magic word to wake up is "toothbrush" of course.

While explaining the game I stress that whenever they go to see the dentist they can just sleep, and feel good, and nothing can bother them; it's just nice. The idea of a game and sleep is accepted easily by the children and a majority follow the suggestion readily.

When the children were called to the clinic several days later they came willingly. Having been previously conditioned to sleep, most of them went immediately into a hypnotic trance again, often to the depth of achieving glove anesthesia. Those who followed the suggestion were completely relaxed throughout treatment. In this state they sat quietly, their mouths stayed open continuously, and treatment was no problem. Several relaxed to the point of falling into natural sleep and snoring! This behaviour is in contrast to those who did not accept the idea of sleep (could not be hypnotized) and who invariably cried and squirmed -- typical, "difficult children".

Less than ten minutes per class was spent in the initial conditioning to "sleep". Following this, it takes seconds in the chair to achieve sufficient depth of trance.

Because the first dental visit was not a traumatic experience for these children, they were quite happy to return for following visits, each time going quickly into a hypnotic trance upon suggestion. In this way, instead of having frightened, unmanageable children, we have interested, cooperative ones; a good basis for continuing successful dental care. " . . . you can just sleep, like a rabbit."

Submitted By:
Miss V. Bax, R.D.H.

THE ADHA ANNUAL SESSION - New York 1969

THE ADA TV NETWORK PROGRAM

The American Dental Hygienists' Association extended an invitation to the CDHA President to attend their 46th Annual Session in New York City -- October 12 to 16th. The ADHA has sent their President on two occasions and their 1st Vice President on one occasion to attend three CDHA annual conventions -- at which time they offered much valuable advice and encouragement. While we were pleased to be asked to reciprocate, it was not until close to the date that this decision to be represented could be made.

Coupled with attendance at the ADHA Session, was the opportunity for the CDHA President to participate in a TV program produced by the American Dental Association. The program entitled "Dental Hygiene Around the World", was taped and shown in New York during the ADA-ADHA Convention. It consisted of a panel of four hygienists discussing the practice of dental hygiene in different nations, including the U.S.A., Canada, Great Britain and the Netherlands. The Editor of the Journal, "The British Dental Hygienist", represented Britain on the panel. A short description of duties of a hygienist with the S.S. Hope, an American health ship active in South East Asia was also provided. The CDHA was pleased to have the opportunity to represent dental hygienists in Canada on this program, especially since the Convention was a joint meeting with the Federation Dentaire Internationale and hence, the program would have an international audience.

The ADHA were very considerate hostesses and, as your representative, I was accorded the attention due an honoured guest. After being introduced to the House of Delegates, I was invited to attend all business sessions desired, including the reference meetings where problems and issues are discussed very frankly. Complete reports were made available to me. It should be noted here that the annual session of the ADHA consists of business meetings held throughout the 4 day period, with fewer scientific and social events. Their structure of government, due to larger membership, is more complex than ours. Hence, their Convention is a heavier work session; whereas, the CDHA officers and delegates conclude our association business at the 1-1/2 day Board Meeting prior to the scientific portion of the convention. Without going into fuller details, let me say that the experience was most enlightening and helpful. Aside from studying their organization and advanced operational system, I found the opportunity to talk with hygienists, many of them leaders in their fields of education, private practice, etc., most stimulating, informative and helpful for the development of our Canadian future. Much literature is now in our files -- brochures describing different educational institutions for dental hygienists, information on dental hygiene legislation, agencies and committees where the ADHA has a voice, names of people or agencies to contact for specific information, and much, much more.

I should not leave you with the impression that the session consisted entirely of business meetings. The theme of the session was "Continuing Education" and excellent papers were presented by four respected essayists. It is hoped that these papers will be available for publication. The CDHA and the British Dental Hygienists' Association were represented at the head table at the President's Luncheon, the major social event of the session. The CDHA was complimented on its maturity, fast growth rate and keenness of members and I was proud to represent you. Also of note is the convention held by the Junior Membership of the ADHA at the same time as the ADHA Session but independent of it.

The ADHA marked their 46th year of operation at this session, whereas the CDHA is now in its 7th year of operation. However, the problems and practice of dental hygiene in the United States are remarkably similar to ours in Canada. The future for both is uncertain and discussion as to expansion of duties, creation of another auxiliary, maintenance of professionalism and quality of service, membership and recruitment are at similar levels in both countries. While American solutions

may not be applicable in Canada, the necessary research conducted through ADHA studies will prove invaluable guides for us. The fostering of a spirit of international fraternity for dental hygienists is to be encouraged. A close liaison should be developed and maintained between the CDHA, the ADHA and all other national associations for allied dental personnel who share our goals and interests.

Reported By:
CDHA President
Mrs. Pat Johnson

REMEMBER!

The 7th Annual Convention

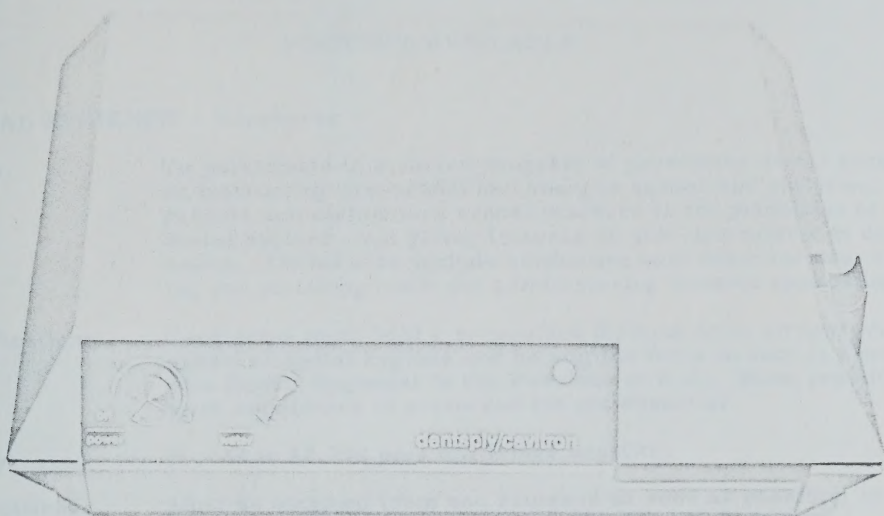
July 1st - July 4th

Winnipeg, Manitoba

Your Convention Chairman:

Karen Wise
883 Campbell Street
Winnipeg 9, Manitoba

Feel free to contact her about table clinics, etc.



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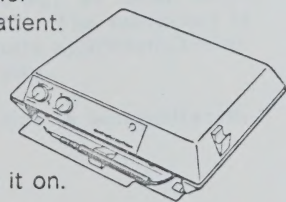
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- Qualifications:** Candidates must hold a recognized diploma from an approved school of dental hygiene and be eligible for a licence to practise as a Dental Hygienist in the Province of B.C. Some practical work experience is preferred but not essential.
- Salary:** \$6,444 to \$7,704 plus full fringe benefits.
- Applications:** Must be obtained from and returned as soon as possible, to the Director of Personnel Services, 453 West 12th Avenue, Vancouver 10, B.C.

DENTAL HYGIENIST - North Shore, Vancouver

Applications are invited for the position of Dental Hygienist with the North Shore Health Unit. There are three dentists on staff. For further information regarding salary and fringe benefits, please write to Dr. S.P.C. Casey, Medical Health Officer, 253 East 14th Street, North Vancouver, B.C.

NOTICE FROM THE BROOKDALE HOSPITAL CENTER - New York Linden Boulevard at Brookdale Plaza, Brooklyn, N.Y. 11212

The Department of Dental and Oral Surgery at the Brookdale Hospital Center, Brooklyn, New York is offering an approved residency as well as three internships in general practice for the academic year 1970-1971. The residency is available to candidates who are graduates of New York State approved Dental Schools, and who are eligible to take the N.Y. State Boards.

In addition, an internship-residency program in pedodontics is being offered, a program of two years' duration.

For further information and application, address:

A. Norman Cranin, D.D.S.
Director of Dental and Oral Surgery
The Brookdale Hospital Center
Linden Boulevard at Brookdale Plaza
Brooklyn, New York 11212
U.S.A.

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DENTAL HYGIENE - North York, Ontario

NOTICE FROM THE ONTARIO DENTAL BOARD - 1974
The Ontario Dental Board is pleased to announce that the Ontario Dental Board has been established as a separate body from the Ontario Dental Association.

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THE CANADIAN
DENTAL HYGIENIST

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THE CANADIAN DENTAL HYGIENIST

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TABLE OF CONTENTS

Editor's Report	4
President's Message	6
A Question of Priority	7
Unemployment Insurance — Summary	10
CDHA — 7th Annual Convention, Winnipeg	11
Dental Hygiene in Switzerland	13
Message from the Membership Chairman	18
Selections from Student's Papers	19
The Dental Assistant's Program — Saskatchewan	22
Report on the CDA Auxiliary Services	27
Report on the CDA Council on Education	28
Provincial Association News	31

INDEX TO ADVERTISERS

Block Drug Company	26
Dental Company of Canada	30
Dentsply Internation, York, Pennsylvania	17
Johnson and Johnson Limited	4
Medical Examination Publishing Company	3
Proctor and Gamble Company of Canada	5

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EDITOR'S REPORT

As chairman of the committee this year I wish to extend a thank-you to all Journal contributors. I hope that you and others will continue to forward material for our ever-expanding Journal. Please do not hesitate to write if you have an article or experience which would be of value in sharing through our Journal. It is the efforts of those who contribute that makes our Journal possible. Have you an article you could contribute?

To our members and subscribers I hope I have succeeded in gathering material to meet your Dental Hygiene needs and interests

On behalf of the Editorial Committee, I regretfully announce the resignation of Mrs. Patricia Kerr, Editor and Miss Janice Dagg, Editorial Chairman. Mrs. Patricia Kerr and her husband will be setting up a Dental practice in Courtenay, Vancouver Island, B.C. Miss Dagg is being married in May and then going to Europe. A replacement for both of these positions is urgently required. Ideally, both Editor and Chairman and Advertising Manager should be located in the same or neighbouring city. This facilitates better and more efficient communications. Please reply to Mrs. Patricia Johnson, 8 Hallfield Road, Islington, Ontario.

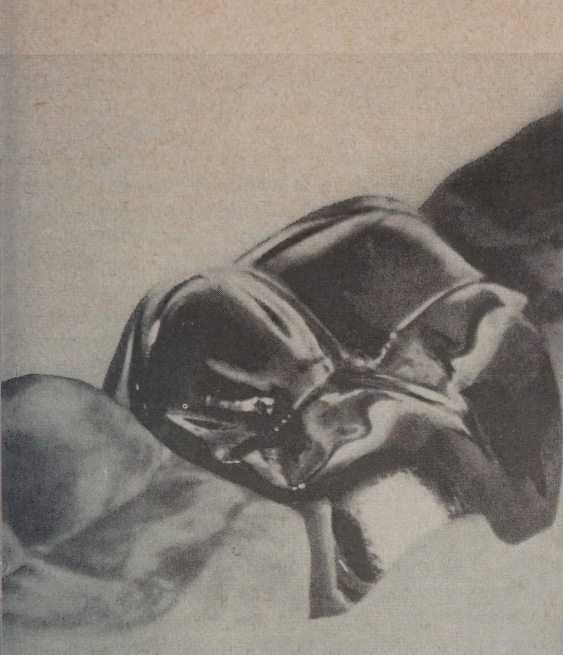
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*The control dentifrice was the Crest formula but without stannous fluoride and stannous pyrophosphate.
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[†]Evaluations by the ADA Council on Dental Therapeutics are limited to dental products made in the U.S.
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PRESIDENT'S MESSAGE

A profession should be noted for its altruism and should continually strive to elevate its standards of practice, education and services — purposes best achieved for the dental hygiene profession through the Canadian Dental Hygienists' Association.

I would like to examine our standard of education more fully with you. Education is one of the foundations of our profession and permeates almost every facet of our activities. Education must be regarded as the "route" to the possession of the cap, pin and license of a dental hygienist. If you wish to attain these symbols then the acceptance of same commits you to an everlasting journey on "the educational route." To remain a member of the profession is an honour which must be earned through the individual pursuit of excellence in practice; excellence achieved by a maintenance of current knowledge of the science and art of dental hygiene.

Continuing education can involve, for example, individual reading, informal study groups and workshops, lectures at conventions and meetings, and attendance of formal educational programmes. It is heartening to see the continuing education programmes available in dental hygiene which have been offered by some of our university dental hygiene schools. The CDHA members must encourage and develop programmes, to be available to all hygienists in Canada. The entire field of education is altering and many means and media must be considered in the provision of continuing education programmes.

I would hope that every dental hygienist feels as strongly as I do:

- It is our individual responsibility (and should be) contingent on our membership in this profession, to participate regularly in accepted programmes of education for self improvement as a practitioner;
- Further, the CDHA should immediately develop a policy which, in co-operation with the dental hygiene schools, will encourage the development of educational programmes for graduate hygienists;
- It is CDHA responsibility to ensure continued use of worthwhile programmes by the promotion of continuing education as a means of improving dental hygiene practice and developing it as a life-long career.

The Executive and the Education and Recruitment Committee are presently compiling information on available programmes in Canada and the United States.

In this discussion on education, I would like to include the undergraduate level — programmes available to the student wishing to qualify for a diploma in dental hygiene. We will restrict ourselves to the proposed development of programmes in post-secondary, non university educational institutions, (eg: Junior colleges, Colleges of Applied Arts and Technology; C.E.G.E.P. — colleges of general and professional education (Quebec; etc.).

Through participation in discussions, seminars, community affairs, etc., we are all aware of the lack of dental care services for so many of the people of Canada. Provincial and federal studies, such as the Royal Commission on Health Services, have compiled statistics which illustrate most graphically this inadequate delivery of dental care. All concerned associations and agencies have tried to arrive at the best means of improving this critical problem.

Through my relationship with the CDHA and its related associations and as a result of participation on a provincial planning committee, I foresee the development of dental hygiene diploma programmes in post-secondary, non-university institutions in the near future, for the purpose of producing many more of the present auxiliary. This auxiliary may have expanded duties. I refer you to the report on the CDA Council Education published in this same issue. Initially, I had some concern over the possible production of a second grade hygienist, which was certainly not in the public's or the profession's best interests. I was aware that some of these programmes in the United States are not of the quality that we would desire. However, a study has disclosed that many are equal in all respects to our approved courses and some would provide excellent examples of improvements. I am now convinced that this method of educating hygienists, while not desirable as establishing all schools at faculties of dentistry, can be most beneficial in alleviating the present conditions of dental care delivery in Canada.

I am confident the CDHA recognizes its obligation and will co-operate with the CDA and the post-secondary institutions to ensure that college level courses, approved by the CDA, are established and that graduates meet all requirements for licensure. Qualifications for entry into these programmes must be equal to those for present programmes to ensure that the proposed graduate is in no way inferior to graduates of present

ools. Advance planning and continuing consultation should guarantee that this standard is maintained. The CDHA should provide leadership and support for the establishment of dental hygiene programmes in educational settings, offering programmes designed for transfer to the baccalaureate level.

A third aspect of education involves the license issued upon successful completion of certain requirements which is mandatory for practice in most provinces (Alberta is an exception). With the proposed increase in the number of dental hygiene schools, I would like to see a stronger emphasis placed on the quality of the licensing board examinations which qualify an individual for practice as a dental hygienist. While this association and other groups will make every effort to ensure the maintenance of high standards of education, still there will be divergencies to some degree between so many programmes. Indeed, a certain amount of experimentation in education is to be encouraged. Hence, there is a very real need for a stringent licensing examination, suitably designed and conducted to maintain the high standards of practice we desire. These examinations could be provincial or national in application. Implementation of acceptable qualifying examinations would serve also to screen applicants to the profession of dental hygiene who have not graduated from accredited schools. Only an adequate examination can determine whether such applicants possess suitable academic as well as clinical experience before being entitled to licensure. We have a responsibility to the public and to the dental profession to guarantee that all licensed hygienists meet a required professional standard.

The entire field of education demands our immediate attention. This discussion has not referred to many aspects of education, such as the degree programme for dental hygienists or the requirement for acceptable training programmes, should the duties of the dental hygienist be expanded. Even as we identify some areas of concern, we must never forget that outside influences are continually in flux. Our plans for the future must be adaptable and we must ever seek to improve our professional excellence. Continuing education is an individual programme in which we can all participate immediately.

Mrs. Patricia Johnson
President

A QUESTION OF PRIORITY

"Death and Taxes are unavoidable." Perhaps periodontal disease should be included in this old adage. Cross-sectional studies reveal a great prevalence of gingivitis in the adolescent population. Some 50 years later the majority of these people have need for partial or complete replacement of their dentitions. During this interval very few people avoid dental decay and never still escape the ravages of marginal periodontitis.

Treatment, teaching, research and education have been motivated by the acuteness associated with dental decay. Caries cannot be ignored for any length of time without pulpal loss as the inevitable consequence. Therefore, it comes as no surprise that a great proportion of total dental man hours are spent in treating decay. Curricula in dental schools mirror this allocation of devotion with the result that periodontics has not received its fair share of attention. Consequently, it is understandable why gingival inflammation and bone loss are so prevalent in patients receiving dental care on a regular recall basis. The chronic nature, the slow progression and the absence of acute symptoms of marginal periodontitis are responsible for the patients' failure to present for treatment. The subtle signs of chronic inflammatory disease certainly do not attract immediate attention as do the acute ones of dental decay.

Within the foreseeable future the problem of caries may succumb to the onslaught of researchers, dentifrices, water fluoridation and education. Perhaps then all attention will turn to the conquest of periodontal disease.

The increasing demand for dental attention resulting from the population explosion, education and insurance plans relieving a portion of the financial burden of dentistry have overtaxed the available dental personnel. Relief is being sought by employing dental auxiliaries in greater numbers and broadening their responsibilities in the treatment of dental disease. Dental hygienists are the strength behind the auxiliary movement. The training, capability and devotion of a hygienist certainly qualify her as a dental specialist who can be dedicated to practise preventative dentistry to a sophisticated degree. Unfortunately too many hygienists find themselves in offices where the emphasis lies predominantly on treatment and after initial resistance, succumb to the system and thereafter exert only token effort towards prevention.

This tendency must be resisted and an attitude of prevention be incorporated into every aspect of treatment that is rendered.

Periodontal disease is not usually a problem during the mixed dentition stage and is usually reversible in the adolescent and early adult. This does not mean that a preventative program should wait until that time. Plaque is the most important single factor in the etiology of periodontal disease. Constant retention of dental plaque with its bacterial components progresses, irreversible bone resorption and pocket formation occur as the distinct lesions of marginal periodontitis. Untreated inflammatory disease usually leads to complete destruction of the periodontium. It also combines with a suitable substrate to lower oral pH values and cause dental decay. Plaque, therefore, should be the object of our attention constantly. Its presence should be revealed to the patient by means of disclosing agents and its complete removal be the object of every method of home care. Motivating youngsters in their early teens can be a trying and frustrating experience and yet this is the time when acute depths occur. Oral cleanliness is inseparable from personal hygiene and should be discussed as such. Frequency of recalls for prophylaxis and home care instruction should be adjusted according to the individual patient's interest and performance. Encouragement and reinforcement should accompany the complete removal of plaque and calculus. Patients often volunteer that their recalls should be more frequent because they are "heavy calculus" formers. They should be informed that this is evidence of their own inability to remove the plaque thoroughly on a daily basis and that calculus will appear in two or three days time. Certainly weekly recalls for prophylaxis are not possible or practical. The latter part of every recall interval will then present a considerable amount of inflammation and result in the patient's progression to a severe marginal periodontitis despite bi-yearly recall. In such a situation the dentist or hygienist is supervising the patient's neglect and unfortunately will get credit for it in years to come. If a patient's home care efforts are not adequate there is reason enough to recall him numerous times till his care of his teeth is as professional as yours. An amateur should not be entrusted to care of professional services involved. If a complaint of bleeding when brushing continues, one should re-examine the thoroughness of the subgingival root curettage. If home care efforts are adequate, inflammation should be resolved if all calculus is removed in patients previously suffering from gingivitis or moderate marginal periodontitis. Root curettage is perhaps one of the most difficult tasks in dentistry and demands much more time than it usually is allotted. It is often necessary to spend several hours before root planing is complete. Patients do not return for numerous appointments until curettage is complete if this is presented as the treatment of periodontal disease that they certainly possess rather than just a cosmetic scrub and polish. Patients should know that their periodontal disease will result in full dentures if it continues untreated. This phase of dentistry is perhaps the most badly neglected.

ety-eight per cent of the people thirty-five years of age exhibit bone loss as a sign of chronic gingival periodontitis. Many are faithful dental patients who continue to have their teeth cleaned and polished supragingivally and whose subgingival calculus continues to grow and whose gingival tissues continue to bleed. Examination of serial x-rays taken at six months recall appointments continue to show subgingival calculus and the crestal bone slowly fading out of bite-wing x-rays that are religiously taken for caries detection. The hygienist is asked to take x-rays and chart the cavities but how often is she asked to chart pocket depth? Loss of crestal density and lowering of bone levels often show on these same films. It is difficult to explain the evidence of bone loss in films taken 10 years ago was not brought to the patient's attention and why their periodontal disease was not treated. Forty-five minutes twice yearly is not enough time to dedicate to this task in the majority of adults.

Specifically the techniques of home care should include the use of a soft toothbrush employed with a gentle rotary scrubbing motion directing the bristles apically; encountering the gingivae as well as the teeth. All buccal and lingual surfaces should be brushed and considerable time should be spent. A timing device is a great help. Interproximal cleaning should be spent. A timing device is a great help. Interproximal cleaning should be completed by means of dental floss. An electric brush may be used if the patient repeatedly fails to perform adequately as evidenced by disclosing tablets. Interproximal stimulation and massage should be added where crestal bone loss has occurred and gingival recession is desired. A variety of rubber or plastic aided devices are available. Advanced marginal periodontitis, post-surgical contours, extensive restorations and fixed appliances greatly complicate the home care regimen. Irrigating devices, syringes and yarn, pipe cleaners, picks of soft wood and a variety of other aids should be added to the routine use of the brush and floss to enable the patient to remove plaque meticulously.

In summary, young patients must remove plaque to guard against tooth decay. Efficiency in this task will eliminate the inflammation so prevalent in the adolescent. Calculus is not common in a teenager and persisting inflammation accompanied by adequate oral hygiene confirms this. If plaque and calculus are abundant at every recall the inevitable will be the progression of inflammatory periodontal disease with the premature loss of the teeth. Home care instruction and root curettage constitute the basic skills in the prevention and treatment of periodontal disease. Persisting inflammation, increasing pocket depth, and continuing loss of crestal density and height in the presence of adequate patient care and co-operation demands a more comprehensive treatment plan. Why not avoid this with more dedication to early prevention?

Neil Basaraba D.D.S., M.S.D.
Associate Professor,
Dept. of Oral Medicine
Faculty of Dentistry
University of British Columbia,
Vancouver, B.C.

Summary of Findings re: Unemployment Insurance Payments for Hygienists

1. All employment in Canada under a contract of service is insurable unless specifically excepted by the Act or Regulations. A contract of service is a written or oral agreement whereby one person, the employee, agrees to work for another person, the employer, under an employer and employee relationship. The worker is to do the work personally under the direction and control of the employer in return for some specific remuneration.
2. It is the responsibility of the employer to collect and remit unemployment insurance payments and to keep appropriate records.
3. Conditions under which a hygienist is not insurable:
 - (a) If the hygienist is not working in excess of 24 hours per week and her livelihood is not ordinarily derived from insurable employment, she may claim exemption by filing a Declaration of Inconsiderable Employment, form 587A with the employer at time of hiring. If the employer does not wish to complete the declaration, the hygienist must be insured even though working less than 24 hours a week.
 - (b) A hygienist whose yearly earnings exceed \$7,800 a year, provided her rate of payment is other than by the hour, day, piece or other rate per unit of work. The hygienist would have to be paid on a weekly, monthly or Commission basis. A hygienist whose earnings are not insurable because of earnings in excess of \$7,800 a year as outlined above may elect to remain insured provided certain conditions are fulfilled. Information on this point may be obtained from any office of the Commission.
4. It is emphasized that if any doubt exists regarding the insurability of a hygienist, a ruling in writing should be obtained from the nearest office of the Commission.

C.D.H.A. 7th Annual Convention, Winnipeg

The 7th Annual Canadian Dental Hygienists' Association Convention will be held July 1st - 4th, 1970 at the Centennial Concert Hall in Winnipeg. Mrs. Pat Johnson, President of the C.D.H.A. and Mrs. Karen Wise, Convention Chairman for the C.D.H.A., invite you to join them for four days of fun, learning and laughter. Further information may be obtained from Mrs. Karen Wise, 883 Campbell Street, Winnipeg 9, Manitoba.

DENTAL HYGIENISTS' PROGRAM:

Tuesday, June 30th:

8:00 p.m. Board of Directors' Meeting - first session. Presidents' Suite, Fort Garry Hotel.

Wednesday, July 1st:

8:00 a.m. Board of Directors' Meeting - second session. Presidents' Suite, Fort Garry Hotel.

12:00 p.m. Registration - Centennial Concert Hall.

8:00 p.m. Wine and Cheese Party and Variety Concert, Centennial Concert Hall.

Thursday, July 2nd:

8:00 a.m. Registration - Main Lobby Concert Hall.

9:00 a.m. - 10:30 a.m. To be announced.

10:30 a.m. - 12:00 Noon Dr. S. N. Bhaskar (Washington, D.C.). "Periodontics in General Practice."

12:00 Noon Luncheon - "Gold Room" - Hosted by M.D.H.A.

1:00 p.m. - 3:30 p.m. General Meeting C.D.H.A.

3:30 p.m. - 4:30 p.m. Table Clinics.

5:30 p.m. Presidents' Ball - Winnipeg Auditorium.

Friday, July 3rd:

9:00 a.m. - 11:30 a.m. Panel Discussion - "Dental Hygiene - What is its future?"

11:30 a.m. - 1:00 p.m. Informal Luncheon - Concert Hall.

1:00 p.m. - 2:00 p.m. Dr. Thomas Barbr (Los Angeles). "Interceptive Orthodontics."

2:00 p.m. Panel Discussion - "Clinical Application of Basic Research" or Commercial Exhibits.

7:00 p.m. Cocktails - "International Inn."

7:30 p.m. Dinner - Hollow Mug Theatre Restaurant. Installation of New Officers. Presentation of C.D.H.A. Pins.

Saturday, July 4th:

9:00 a.m. - 10:00 a.m. Dr. W. W. Shorthill (Winnipeg). "Utilization of a Dental Hygienist in a Group Practice."

10:30 a.m. - 11:30 a.m. Dr. L. Golub (Winnipeg). "The possible future role of the Dental Hygienist in the diagnosis of Periodontal disease."

12:00 noon - 1:30 p.m. Informal Luncheon - Concert Hall.

1:30 p.m. Free time.

6:00 p.m. - 12:00 a.m. Wind-up Party. Highland Curling Club.

Registration Form — Winnipeg Manitoba
Canadian Dental Hygienists' Association Convention
JULY 1st — 4th, 1970

Fees	Pre-Reg. June 1st	Post-Reg.
C.D.H.A. Member	\$25.00	\$28.00
Non Member	28.00	30.00
Junior Member	21.00	21.00

Husband or Escort attending — \$7.00
Evening at Hollow Mug Theatre Restaurant.

Registration Fee includes all Scheduled Scientific and Social Sessions (three luncheons Wednesday Welcome Party, Evening at Hollow Mug and Saturday Wind-Up Party) except Presidents' Ball.

Miss, Mrs. C.D.H.A. Member
Yes No

Address

Did you include \$7.00 for husband or escort? Yes No

Cheque (plus exchange) enclosed for \$
Payable to: Canadian Dental Hygienists' Association.

Mail to:
Mrs. Wendy Wilder
200 Queenston St.,
Winnipeg 9, Manitoba

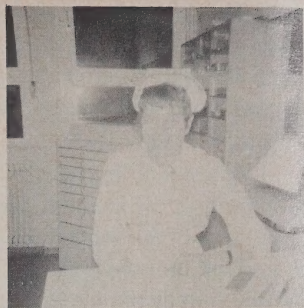
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DENTAL HYGIENE IN SWITZERLAND

Introduction

In 1963 the dentists of Zurich, Switzerland began inviting American and Canadian dental hygienists to work for them in their private dental offices and in their dental institute. Since that time the dentists of Geneva, Lausanne, Basel, Olten and Chur have also been welcoming dental hygienists. Today there are nearly 40 dental hygienists working in Switzerland, four of these work full-time in the four university dental institutes at Zurich, Berne, Geneva and Basel; others work with the World Health Organization in Geneva, and the majority are employed in private dental practices. Seventeen of these are in Zurich, six in Geneva, five in Basel, five in Lausanne, one each in Olten and Chur.

Presently there is one Canadian dental hygienist working in Switzerland. Miss Mary Robb of Regina, Saskatchewan, arrived in February this year to work in the dental policlinic in Lausanne. Miss Diane Hailes of Camrose, Alberta, left this position in February after more than two and one half years and her impressions are included here. Miss Burglind Blei left Zurich in March after completing a one-year contract in the private practices of two general dentists and a periodontist.

Type of Employment

University Dental Institutes — In the dental institutes of Basel and Zurich, dental hygienists perform placement services for private dental practices and act as general liaison between Swiss dentists and North American dental hygienists. In all of the institutes the dental hygienist performs clinical services for patients of the institute, for private patients of professors, and in three of the institutes spends a portion of her time giving instruction in prophylaxis techniques to dental students. Hygienists in the institutes at Zurich and Basel are beginning to be involved in dental research projects. Institute dental hygienists sometimes participate in dental programs regarding oral hygiene, periodontics or dental hygiene.

Private Practice — Dental hygienists in private practice are engaged primarily in performing prophylaxes, giving patient education, and in exposing radiographs. Private practice in Switzerland is similar to that of North America; however, most of the population has a lifetime accumulation of oral deposit and a background placing little value on oral hygiene. Ultrasonic scaling equipment is essential for initial scaling in the majority of prophylaxes, and previous experience with periodontal patients is invaluable. The dental hygienist's ability to speak the appropriate language increases her effectiveness in changing the behaviour and attitudes of patients, and makes her everyday life much easier. There is much hard work for the clinical dental hygienist in Switzerland.

The dental hygienist in private practice will usually have an opportunity while living in Switzerland to give a table clinic presentation at the national Swiss dental meeting or at a regional dental meeting. These and other opportunities to give information about oral hygiene procedures or utilization of the dental hygienist can be very satisfying.

Conditions for Employment

Any dental hygienist with a license and a good recommendation from the U.S. or Canada may work in Switzerland. Graduates of shorter programs in other countries are not permitted to practice. Two Swiss have completed British dental hygiene programs and are not permitted to practice in Switzerland. Only one Swiss has completed a two-year American program of education in dental hygiene, and no Swiss dental hygiene programs have yet begun, though they are planned.

Employment conditions are as follows:

1. A dental hygienist will be required to work for two to four dentists in group or individual practices.
2. The work will consist mainly of prophylaxis, X-rays, and patient education. The hygienist should be able to sharpen instruments, use the cavitron in her work, give fluoride treatments, polish fillings, assist at the chair, and be responsible for a recall system.
3. Five-day week at eight hours per day.
4. Salary: 1500 Swiss francs for first three months
1600 Swiss francs for next nine months
1700 Swiss francs for second year
5. Overseas travel paid one way or the equivalent of \$350. It is possible to have the return paid after working for two years.
6. Paid three-week holiday per year, the time to be agreed upon by both employer and hygienist.
7. Employer will be responsible for securing lodging for the applicant before she departs for Europe. The monthly rent for this lodging is the responsibility of the applicant.

Application Procedures

To apply for employment in Switzerland, send the following in one package:

1. A photocopy of accredited diploma and provincial license.
 2. A letter of recommendation from the school of dental hygiene and present employer (if available).
 3. A recent photo.
 4. An outline in which the following items are included:
 - (a) Full birth-date.
 - (b) Marital status.
 - (c) Educational background (including university, dates of attendance, certificate or degree held).
 - (d) Employment experience since graduation (at least one year working experience mandatory) including name and address of employer(s), position held, and duration.
 - (e) Language background.
 - (f) Procedures performed in present employment.
 - (g) Membership in the Canadian Dental Hygienists' Association.
 - (h) Brief statement of reasons for employment in Switzerland.
 5. For application to the institutes a baccalaureate degree, experience in teaching, administration, or research is desirable.
- Address applications or request for information to Zurich, Basel or Geneva as follows:

Zahnärztliches Institut
Universität Zurich
Dental Hygienist
Petersplatz 11
4000 Zurich, Switzerland

Zahnärztliches Institut
der Universität Basel
Dental Hygienist
Petersplatz 14
4000 Basel, Switzerland

Institut de Médecine Dentaire
Université de Genève, Dental Hygienist
30 rue Lombard
1211 Geneva, Switzerland.

Canadians Living in Switzerland

Diane Hailes — Before Diane came to Lausanne, she studied dental hygiene at the University of Alberta and worked two years in public health at the Sturgeon Health Unit, St. Albert, Alberta. Diane came to Europe inquiring as she travelled about dental hygiene employment and found Dr. Claude Schreyer willing to employ her at the Polyclinique Dentaire in Lausanne. There she has been busy providing prophylaxes, polishing amalgams, applying topical fluoride, giving oral hygiene instruction, using the "douche buccale" (giant water pik), calling interested patients, taking radiographs, using the panoramix, and assisting with surgery under general anaesthesia.

Diane gave a dental hygiene career talk in French to the dental assistants' organization in Lausanne and presented a table clinic in French on patient education to the dental societies of Lausanne and Geneva last spring.

While in Switzerland Diane enjoyed skiing, swimming, equitation (horsemanship), tasting strawberries, cheese, and wines; studying French and French cuisine, and travelling to many castles, museums, and to other countries.

Diane says: "I liked living in Switzerland! At times I find the people a little closed towards strangers, but I must admit that they are extremely courteous and polite. There are many strangers in this country and I don't blame them for wanting to keep to themselves at times.

The climate is very tolerable for me. It has much the same seasonable changes and temperatures as British Columbia.

Living accommodation is not easily found and is relatively expensive; however, I feel this is made up in other areas such as food costs and travelling expenses. The cost of train travel is very reasonable.

It is very encouraging to hear so many languages in current use in such a small country. It is nothing for one person to be fluent in French, German, and Italian.

I feel like culture is all around me here. There is no need to search for cultural entertainment in the fields of music, art, and drama and studies in these fields is equally easily found and encouraged.

I have found my work very interesting and stimulating here at the polyclinique. In particular, the opportunity of assisting the anaesthetist was indeed a boost to my education and understanding of surgery and the employment of complete aseptic techniques.

Being one of four hygienists in Lausanne (at the beginning we were two), there has been no lack of patients for routine prophylaxis! The challenge is overwhelming! Our clinic is the only emergency service for a population of over 150,000 people and there are approximately 100 who see our four dentists every day. The oral hygiene is deplorable. I see at least eight acute N.U.G. patients per week. Of course one must consider that the polyclinique is government subsidized, thus making the cost of dental treatment minimum to patients being treated at the "poli", thus I see many indigents and poorly educated people. I am eager to say,

however, that the people are usually enthusiastic to improve their hygiene.

"The Profession" has been well organized, in that we have an "Act" guiding our salary level and working conditions. It also provides for semi-annual dental hygiene meetings where hygienists throughout Switzerland are invited to an evening of educational and social "stimulus." These meetings are presently being organized by the Zurich Institute.

We do need a school in Switzerland. The transiency of hygienists is tremendous and we realize that it takes at least six months to become acquainted with a practice. When one thinks that hygienists stay an average of 14 months, this is not very encouraging to dentists to set up his office for a hygienist and then have to worry about having someone from Canada or the U.S. new every year."

* * *

Burglind Blei — Burglind was born in Hamburg, Germany, and moved later to Halifax, Nova Scotia. Before coming to Switzerland Burglind studied dental hygiene for three years at the University of Dalhousie and worked the following year in an orthodontic practice. Being able to speak German when she arrived in Switzerland last year was an enormous asset to her. In Zurich Burglind worked for Doctors E. Schlaginhaufen, M. Schijutschky and H. E. Wolf. Her major responsibilities in these three practices were prophylaxis, patient education, taking radiographs and upper and lower impressions.

During the year Burglind had the opportunity to participate in a dental hygiene seminar with Mrs. A. Seck in Regensburg, Germany, as the guest of Dr. Alfred Beck, a periodontist, who is eager, she thinks, to begin a dental hygiene venture in Germany similar to that of the Swiss.

Burglind says: "All in all it has been a very enjoyable year. Reflecting back to my first few months in Zurich, it was, of course, a change in my living habits. Coping with new languages, new people, and new surroundings is always a matter of 'conditioning.' I am enjoying it now, much more than at the beginning. Food is very interesting — new and old international recipes. (Gained a few too many kilos.) Learning the ways, (customs), and living standards of the European people was also an interesting new experience. Switzerland, being centrally located, allows one to take a little trip to France, Austria, Germany, Italy and so on without travelling vast distances. Living here has been I feel a stimulating and educational experience. One is able to get a glimpse of our more historical past and to see just how it has developed into a modern new Europe. This enables one to compare living here, with living in America and thus perhaps allow for a more 'open' view of living in our world today.

Working here also was quite an experience. Seeing a Swiss (European) dental practice and how it functions, and generally, obtaining a glimpse into dentistry in Switzerland has been, I feel, a privilege. I think one gains a little more insight into the individual at work. Opportunities for the dental hygienist are still plentiful. Perhaps our 'worth' has not quite invaded the minds of all the dentists, but I feel the profession of dental hygiene has come a long way since its introduction seven years ago. Working hours are perhaps longer and in certain ways more difficult, but this is really not too important. When one examines the overall picture, European standards in general in the dental field leave something to be desired, but the hygienist can help improve the dental health standards by doing her share.

I really am glad I came even for one year, and I'm glad I had the opportunity to live among the people, to analyze my own feelings about European living and perhaps now to make a more meaningful contribution to my profession, to the world I live in and to myself. Burglind would like to continue her education after returning to North America.

* * *

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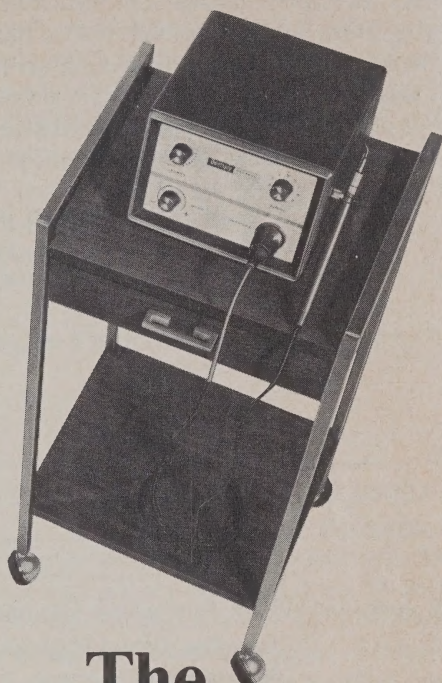
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Message From the Membership Chairman

Over the past seven years, the growth of the Canadian Dental Hygienists' Association has been slow and steady. I would like to take this opportunity to welcome the new members and those who have once again renewed their membership in their professional association. I am sure it is gratifying to the Executive as well that so many of you have taken up the challenge that was given by Mrs. Pat Johnson, President, in her message in the fall issue of the Journal. Your financial support and active participation is always welcome.

May I remind you again to utilize the change of name and/or address form that appears below to keep the Membership Committee informed of your current address.

(Mrs.) Jo Gardner,
Membership Chairman

NAME: _____
OLD ADDRESS: _____
NEW ADDRESS: _____

Notify your Constituent Membership Chairman or send directly to:

Canadian Dental Hygienists' Association
Membership Chairman
234 St. George Street
Toronto 5, Ontario.

NOTICE RE: THE C.D.H.A. CODE OF ETHICS

By now, all members should have received their copy of the recently published CDHA Constitution and Code of Ethics.

A change of wording has been incorporated into the new Code of Ethics. The pronouns 'she' and 'her' were used throughout the original Code of Ethics. In line with CDHA policy of removal of reference to sex discrimination in all issues pertaining to the association and the profession, these pronouns have been changed to the editorial neuter 'he' and 'his'. The new pronouns do not refer specifically to males. Used in such instances, the masculine pronoun refers to both male and female and is preferable to the awkward use of 'he/she' and 'his/her'. We trust that this explanation answers any query that may have arisen.

MOTIVATING FORCES IN PREVENTIVE DENTISTRY:

Sheryl Nichols, March 10, 1969.

Each of us graduate hygienists need spurring on, in the area of patient motivation. Sheryl has done a good job of research in this area. The following are a few excerpts from her paper.

Sheryl defines motivation as "the driving force which causes us to act or behave." It is essential that a dentist or dental hygienist be able to recognize and understand a patient's motives. Extensive study and research reveals the most common motivating force causing patients to seek any form of dental treatment is pain. The patient should be motivated by the dentist and hygienist to realize that preventive dentistry is designed to prevent pain and discomfort.

A "Workshop in Practice Management" held at the New York University College of Dentistry found that:

"The Patient will accept dental care more readily if he is convinced that it will help to:

Keep his own teeth in comfort.

Improve his appearance.

Keep him socially acceptable.

Protect his working ability.

Improve his health.

Lengthen his life span.

Sheryl points out that in most cases social motives are extremely important to preventive dentistry and these secondary goals take precedence over primary biological needs. "Motivation towards better health is probably the least effective form of persuasion to use. The desire for better health must be translated to the patient in terms of social acceptance or some other dominant appeal." Sheryl elaborates on individuals needs which motivate a person towards better dental care: the need for self-approval, family pressures, social pressures, and the desire for status. Most parents can be won over to the "Preventive dentistry team" because of their concern for their children. Sheryl points out, scaring a patient into accepting a certain preventive plan is: 'A short cut which often produces quick results that may be either good or bad.: The concluding words of the essay state: 'Education, understanding and good personal rapport are the key to effective patient motivation.:'

Thank you, Sheryl.

THE EFFECTIVENESS OF AUTOMATIC TOOTHBRUSHES AS
COMPARED TO MANUAL TOOTHBRUSHES

Arna Saper, March 10, 1969.

Arna has done an excellent survey of the literature available in this area. It is impossible to reiterate all that she found in this small space. However, below, you will find some of her conclusions.

The effectiveness of automatic toothbrushes versus manual toothbrushes was examined as to effect on keratin formation, effect on gingival tissue health, effect on periodontal disease and treatment, degree of abrasion and use with retarded children.

Arna found her task of evaluating studies comparing the brushes hindered by lack of objectivity in some studies restricted studies, vagueness, atypical groups, too short studies, inaccurate scoring. Initially Arna found overwhelming claims made in favour of the automatic toothbrush compared to the manual toothbrush. However, when the data and methods were evaluated most of the claims could not be considered proven.

She found though, that in cases of marked muscular inco-ordination as found in child and elderly people as well as in individuals suffering from mentally retarding and devilitat diseases, the automatic toothbrush would appear to be superior to the manual toothbrush. all other cases for example, promotion of keratinization, prevention and treatment of gingiv and periodontitis, the automatic toothbrush and the manual toothbrush at the present ti appear to be equally effective.

In the final analysis, it is not important whether the manual toothbrush or the automa toothbrush is used; it is the frequency of brushing, the timing of the brushing and the meth of brushing which are of ultimate importance in obtaining and maintaining good oral hygie

Thank you, Arna, this is a topic many patients inquire about in the everyday practice.

RESEARCH AND DENTAL BENEFITS OF FLUORIDATED WATER

Gladys Syrnyk, March 10, 1969.

Gladys supplied us with a comprehensive review report on the above topic. Below is a condensed version of major studies on this subject.

In 1907 Dr. Edgar McKay first noticed the relationship between fluorosis or mott enamel and dental decay at Colorado Springs, Colorado. Dr. H. Trendley Dean in 19 compared the incidence of dental decay in two Illinois cities Galesburg and Quincy. Galesbu 1.8ppm fluoride and Quincy fluoride free. REsults showed the caries rate of 12-14 year olds Quincy was three times the rate observed at Galesburg. In 1941 Bibby compared lactobacilli counts in Quincy and Galesburg. 38% more children had counts of over 30,000 lactobacilli cc. of saliva in Quincy compared to Galesburg. In 1945 studies were carried out confirmi Dean's hypothesis that the supplementation of fluoride to deficient water supplies to optimum level of 1ppm. would reduce dental decay by about 60%. Comparison of results w and without fluorine over a period of 15 years was done in Evanston and also compared to C Park, a fluorine free area. Children between 6 and 14 were chosen. In Evanston a 64.5% reduction in the rate of decayed missing and filled teeth was noted in 7-year-old children. Oak Park there was an increase in decay. After 15 years of fluoridation in Evanston, an average rate of reduction in tooth decay of 2.75 teeth per child resulted.

In 1946 the Brantford Caries study was undertaken to determine whether the incidence of dental decay could be reduced among children using previously fluoride-deficient water / the controlled adjustment of the water supply to a concentration of 1ppm. The study began with a comparison of dental caries experience in native Brantford children, Stratford child 1.6ppm and Sarnis children - fluoride free. The mean tooth mortality rate recorded per ce hundred children showed Sarnia with an average of 81.74, Brantford 31.15 and Stratford 25.44. The mean decayed missing and filled permanent teeth per child were recorded at 8.04 Sarnia, 3.90 at Brantford and 3.73 at Stratford. Caries free children:

Sarnis - 2.09%.

Brantford and Strantford - 18.40%.

A similar study over 15 years was conducted at Grand Rapids where the water was adjusted to 1.0 ppm. in January, 1945. 28,000 children were examined in 1944-45 for baseline dental caries data. After 15 years the total caries experience was lowered by 50-63% in the 12-14 year olds and by 48-50% in the 15-16 year olds (born after fluoridation). This study showed the relationship of fluoride to caries attack but also the longer a person is in contact with fluoride the greater the dental benefits.

Further research was done in Brandon whose water was fluoridated in March, 1955. After 5 years the results showed:

An increase of 27% in caries free children in the 6-8 year old group.

An increase from 9.5% to 17.12% in 1970.

And no change in the 12-14 year old group.

There was an improvement in 6-8 year olds from 32.83% in 1955 to 64.35% in 1960 with
ries free first permanent molars.

Thank you, Gladys — perhaps we can use the above results to help convince our neighbours
tients and friends to vote yes to fluoridation.

THE DENTAL ASSISTANT PROGRAM
SASKATCHEWAN INSTITUTE OF APPLIED ARTS AND SCIENCES
SASKATOON, SASKATCHEWAN
By Mrs. Corinne Falconer R.D.H.

INTRODUCTION

Traditionally only two members of the dental health team (the dentist and the dental hygienist) have received formal training. The third member, the dental assistant, learned while on the job — taught by her employer. In keeping with the trends toward institutional training in many other areas of employment, it is not unusual now for the dental assistant to receive formal training through special high school programs, technical schools or community colleges. The formal training is most desirable. The graduate is knowledgeable about dentistry and the functioning of the dental practice. She is reasonably competent in the many areas which normally become her responsibilities and she is able to work in any dental practice and within a short time adapt to it. The dentist has to spend a minimum of time training her and as a result he can continue to devote his attention to his patients without the serious disruption that is so infrequent when a dental assistant leaves a practice to be replaced by an untrained girl. Such interruption of routine during on the job training can affect the number of patients receiving needed treatment and thus the income of the dentist. Utilizing a trained dental assistant can minimize these effects. Naturally the dental assistant who has had a year of training will command a higher salary than her untrained counterpart; it is the responsibility of both the school and the student to make sure that the difference is entirely warranted.

Formal training of dental assistants has an added interest for dental hygienists because it opens up another job opportunity for them. Many training programs are organized and run by graduate dental hygienists. This can be stimulating, interesting and rewarding. Certainly it is a challenge. It is with this in mind and the fact that dental assistant training programs are relatively new and are increasing in number each year, that this article on the Dental Assistant Program in Saskatoon has been written.

HISTORY

The Dental Assistant Program in Saskatchewan had its beginnings early in 1965. An Advisory Board was set up to determine:

- a) the need for formally trained dental assistants in Saskatchewan.
- b) the type and length of training required.
- c) the prerequisites for the course.
- d) the facilities needed.
- e) the staff required.

however, it was not until 1967 that plans became more concrete. At that time the Saskatchewan Institute of Applied Arts and Sciences underwent expansion. The Dental Assistant Program facilities, which include a dental laboratory, three dental operatories, an X-ray room and dark room, reception area, storage areas, staff offices and classroom, were planned for as part of the construction project.

The first class commenced on October 7th of 1968. Of necessity, both the first and second classes have been limited to fifteen students. However, interest has not been lacking. Over 100 girls applied for each class. A similar influx of applications is expected for the 1970-71 class. At the same time enrollment will double.

MISSION REQUIREMENTS

At present the admission requirements are as follows: the applicant must have a complete Grade II (no subjects are specified although courses in bookkeeping and typing are assets), she must be seventeen years of age on entering the Program (no upper age limit is stipulated) and must have a complete medical examination and dental examination no more than three months prior to registering in the course.

THE TYPE AND LENGTH OF TRAINING

The length of training is thirty-six weeks. It includes lectures, demonstrations, laboratory and clinical training and externship training. In the latter the students spend six weeks in different general dental practices in Saskatoon. The first four weeks of externship training are dispersed through the fall and early spring terms but on completing her training, she spends two weeks in a row in one dental office. At this time she should be able to assume all the responsibilities of a fully qualified dental assistant. Each student also spends one week in a specialist's practice. (In Saskatoon the week is spent in an orthodontic office because there are no other types of specialist in the city). Through externship training the students see how different dental practices function. They observe and learn to adapt to new routines. The dental assistants in the offices contribute their knowledge and experience to the training of the students as well. The students enjoy this part of their training and try to become responsible functioning members of the dental team in the short time permitted.

STAFF

At the present time both dental and non-dental personnel contribute to the training of the dental assistants. The Program is organized and co-ordinated by the Head Instructor who is a dental hygienist. She is supported by another dental hygienist, two dentists, one dental laboratory technician and four other instructors from departments within the Institute. Personal Care and Development is taught by an instructor from Beauty Culture, Psychology and Communications are taught by Related Subjects personnel and Nutrition is taught by a nutritionist. The two dentists assist in the teaching of basic sciences and in teaching of some operative and assisting procedures. The laboratory technician instructs in dental laboratory materials and techniques.

AIMS OF THE PROGRAM

Any training program must be guided by certain aims or objectives. The Dental Assistant Program is no exception. The objectives are threefold:

- a) to train the students in all the skills and procedures necessary in the operation of dental operatories (tray set-ups, sterilization techniques, patient reception and dismissal procedures, chairside assisting, care and manipulation of dental materials, and equipment maintenance).
- b) to train the students in all the skills and procedures necessary in the daily operation of a dental office (bookkeeping, typing, filing, patient records, appointment making, supplies ordering, and telephone technique).
- c) to train the students to perform certain intra-oral techniques which will make the graduate more valuable to the dentist and his practice.

CURRICULUM

All the subject matter and practical work support and help to achieve these objectives. The

curriculum includes:

- Introduction and Orientation
- Terminology
- Dental Specialties
- Dental Public Health, Community and Preventive Dentistry
- Anatomy (Gross, Dental) and Oral Physiology
- Bacteriology and Sterilization
- Pathology
- Pharmacology and Anaesthesia
- Diet and Nutrition
- Radiography
- St. John Ambulance Course
- Emergencies in Dental Practice
- Equipment: Components and Maintenance
- Instruments: Identification and Care
- Dental Materials
- Dental Laboratory Materials and Techniques
- Preclinical and Clinical Training
- Practice Management
- Externship Training
- Psychology
- Communications
- Personal Care and Development

Because many of the above subjects are included in other dental assistant training courses and because space is limited, there is no need to describe them here.

ADDITIONAL DUTIES

The Saskatchewan Dental Assistant Program has been leading the way in teaching certain intra-oral techniques to the dental assistant students. These are permitted under the By-Laws of the Saskatchewan Dental Act. Under the supervision of a dentist the graduate dental assistant may:

- a) apply rubber dam
- b) apply matrix bands
- c) take a full mouth survey of X-rays
- d) take study model impressions
- e) polish teeth
- f) apply fluoride topically

The trend towards enlarging the duties of the dental assistant is spreading in Canada, stimulated, no doubt, by the increasing demand for dental health services and the lack of trained dental personnel. Certainly in Saskatchewan the discrepancy between the need for dental services and the ability of the dental profession to provide them is most evident and discouraging. With the establishment of the Dental Assistant Program and the graduation of trained dental assistants, it is hoped that the dentists will be able to extend their professional skills and knowledge to more people and thereby help to ease the problem . . . if only a little.

THE FUTURE

So far one class has graduated. They found jobs immediately. The second class graduated in May. Judging by the enquiries already, they shall have no trouble in finding positions either. The class will expand in the autumn and already plans are being made to improve the Program.

ental assisting is a growing and developing profession in Saskatchewan and the future looks
ght.

QUIRIES

Any enquiries regarding the Dental Assistant Program can be directed to:

Mrs. C. Falconer,
Program Head,
Dental Assistant Program,
S.I.A.A.S.,
Box 1520,
SASKATOON, Saskatchewan.

CHAIRSIDE ASSISTING

4-Handed Dentistry

N.B. student is anticipating the dentist's needs and is ready to hand him the matrix band and retainer.



Mrs. CORINNE FALCONER

Program Head (standing)

Students: Miss Norma Stone polishing anterior teeth of fellow classmate Miss Grace Weinmaster.

DENTAL ASSISTANT STUDENTS

Miss Gloria Rotzien (standing)

Miss Juliana Thiessen (seated)

Taking radiograms



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- **Superior Clinical Results**—five independent clinical studies show Sensodyne helps 9 out of 10—completely relieves 2 out of 3 hypersensitivity patients.
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REPORT ON THE C.D.A. AUXILIARY SERVICES COMMITTEE ANNUAL MEETING

Submitted by: Mrs. Pat Johnson, President

The CDHA was represented by the president, Mrs. Pat Johnson, at the two day meeting held on March 9th and 10th, 1970. A report of CDHA activities was presented to the committee, along with an outline of various projects and problems to be faced by this association in the near future. In view of the growing importance of dental auxiliaries in the provision of dental services, the need for a more active liaison with this CDA committee was discussed fully. It was suggested that a more meaningful relationship, other than the usual report to this committee of past and present activities, could be beneficial to all organizations concerned. Co-operative studies on the development of auxiliaries — education, utilization, legislation, etc. — could provide the basis for progressive recommendations and policies for the future. The final details of achieving closer liaison will be further discussed by the two associations.

The benefit of vital continuity, achieved by having the representatives of concerned associations remain in their respective positions for a continuing number of years, was recognized. The Auxiliary Services Committee will request that the CDHA appoint a representative to their committee who will hold this position for several years.

The CDHA was advised of the benefits of appointing a permanent officer (e.g. — Executive Secretary) to assist the incoming Executive Council and Directors; to offer continuing liaison with other agencies; because of previous attendance at all Annual and other meetings of note to offer background information, interpretation of past actions and advice based on experience; to provide a ready and accessible contact to the public; to promote association and professional interests; and to offer many other advantages. Any growing organization reaches a state of maturity when such an executive appointment becomes necessary. It was suggested that the CDHA was fast approaching this maturity. We responded that the CDHA recognizes the advantages of such an appointment but that our size means there are many factors to be considered. However, the CDHA will seriously consider this recommendation, with a view as to when to implement it.

One important recommendation passed at this meeting is as follows:

Whereas regulations governing the practice of dental hygiene are currently encompassed in provincial dental acts,

Therefore be it resolved that the Auxiliary Services Committee supports the principle of dental Hygiene having a voice on provincial dental licensing boards,

and recommends that the Board of Governors also endorse this principle and encourage the provincial licensing boards to give it careful consideration.

Another resolution of this committee is as follows:

Whereas there are many possible developments in the use of auxiliaries in the practice of dentistry in Canada,

and

Whereas the licensed dentist must assume the ultimate responsibility for the welfare of the patient and the competent performance of all dental services, irrespective of the personnel involved in the delivery of these services,

There Be It Resolved,

That is it the right of the dentist, subject to his licensing authority, to delegate to mally trained auxiliaries over whom he exerts effective supervision and control, s duties that do not require the professional knowledge and skill of the dentist.

Reports were presented by all members of this committee, i.e. — one from each province the present situation with dental auxiliaries in their respective provinces. These reports are r on file for study and copies will be distributed to the Manpower and Utilization Committe the CDHA. The "Statement of the CDA: The Auxiliary in Canadian Dentistry," presented the CDA at the joint ADA-CDA Board Session in July, 1969, is also on file now. In reading reports of the provinces, the comparison of the development of more progressive legislat with respect to all dental auxiliaries was very interesting. It was encouraging to learn that s provincial auxiliary services committees have established a Liaison Committee, with ec representation from the dental, dental hygiene, dental assistant and dental technic associations. The formation of such committees should be encouraged in all provinces.

The CDHA appreciates the opportunity to be represented at the Auxiliary Serv Committee meetings. We look forward to a continuing and fruitful relationship with committee and with the CDA in the future.

REPORT ON THE ANNUAL MEETING OF THE C.D.A. COUNCIL ON EDUCATION CDHA Representative: Mrs. Pat Johnson, President

The CDHA was represented by the president, Mrs. Pat Johnson, at the February 19th sess of the three day meeting. Valuable experience and background knowledge is gained by CD representation at these meetings.

Of particular interest to the CDHA was the acceptance of a report which had been presen last year to this Council. This report was entitled, "Guidelines for the Education of De Hygienists." It essentially provides guidelines for the development of degree programmes at university level and also diploma courses in post-secondary, non-university institutions. report, well prepared, presents a concise but thorough study.

The CDHA requested and was granted one alteration to the report before it was accepted Council. This alteration specified that "successful completion of the requirements for a diplo in dental hygiene should apply as credit towards the Degree for Dental Hygiene." It a specified that "in designing such curricula (diploma programs at post-secondary, non-univer institutions), consideration should be given to the possibility of courses being subsequer acceptable as credit for courses of higher qualification." That is, graduates of a diploma co at a non-university institution should ideally have taken courses which could be recognized credit towards a degree program offered at a university.

The report further recommended that dental and dental hygiene education representati should become actively involved in the development of new programmes in dental hygi education. It was also suggested that dental and auxiliary Advisory or Liaison Committees Boards be organized and operated in continuum and in collaboration with the educatio institution which does not possess a dental school, to provide support and consultation successful and sustaining operation. The Board should be composed of individuals represent the educational institution, the local dental society and the local dental hygienists' socie Dental hygienist representatives should be experienced individuals, actively engaged in pract or public health service, and interested and experienced in the education of hygienists. report goes on to discuss particular responsibilities of this Board.

With the publication of these guidelines, I foresee much activity in the establishment dental hygiene programmes at non-university institutions in the very near future. The CD

its constituent members would be wise to immediately compile all suitable background material to be used by any members who are asked to serve on such an Advisory Board. We will be given an opportunity to contribute directly to the future education of our profession; we must prepare ourselves to meet this opportunity and to demonstrate our value to such Advisory Boards. Hence, we must ensure that our representatives are fully informed and contributing members of any such committee. Enhancement of the image of the association relies on this preparation.

Members will also be interested in the recommendations of this report, with respect to faculty for schools of dental hygiene. The selection and determination of qualifications of faculty is the prerogative of the parent institution. However, the report suggests that the programme be administered by either a well oriented dentist or a qualified dental hygienist, the latter preferably with a baccalaureate degree or its equivalent. Dental hygiene instructors should be experienced in the practice of dental hygiene and where possible, should have a degree qualification.

Of interest to members will be the request I have received from the Council on Health, to assist Dr. J. Speck in revising the "Minimum Requirements for Approval of a School of Dental Hygiene," in accordance with the above new guidelines.

A second report presented at this same Council meeting discussed minimum requirements and a mechanism for accrediting courses in dental assisting. In the section pertaining to faculty, the recommendations for a programme director were made:

- A Dentist with experience in Dental Assisting and current private practice or public health utilization of assistants.

- A Dental Hygienist with a baccalaureate qualification, teaching, practice and dental assisting experience.

- A Dental Assistant with the baccalaureate qualification, recent dental assisting experience and/or graduation from an accredited course for Dental Assistants.

If compromises are necessary, due to scarcity of qualified staff, it is recommended that a dentist be appointed on a part-time basis to instruct in those areas where neither a diploma holding hygienist or a certified dental assistant is qualified by educational background to teach. Both these reports are in the President's file and are available upon request.

ATTENTION: DENTAL HEALTH MANUAL

The Department of National Health and Welfare wishes to make known that the Dental Health Manual is available by mail from the Queen's Printer, Ottawa or at Government bookshops listed below. The price, subject to change without notice, is one dollar (\$ 1.00). The catalogue number is H55-169.

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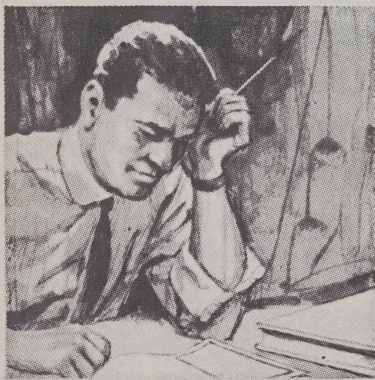
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PROVINCIAL ASSOCIATION NEWS

SUMMARY OF ADHA ACTIVITIES

Dental Health Week — March 9-14 — During this week we concentrated on making the public aware of the importance of good dental health. Financial assistance for the projects was obtained from both the Edmonton and Calgary District Dental Societies.

Several Edmonton institutions such as orphanages, hospitals and residence homes were visited by volunteer dental hygienists for talks or films. This has been done in past years and is to be much appreciated.

Radio spot announcements, newspaper coverage and a morning TV interview were other features of the week. The Popcorn Playhouse kiddies show featured a skit written and acted by dental hygienists. Dental Health posters were displayed in all Edmonton Safeway stores during the week.

A large window display depicting the Dental Hygienist teaching students the rules of dental health was set up in Eaton's downtown store.

Plans were made to have a TV sportscaster interview Dr. Blackburn on the topic of mouthguards. During the interview a dental hygienist will be filmed taking the impression and working on the custom made acrylic mouthguard. Dr. Blackburn has done three years research on mouthguards.

The Calgary dental hygienists chose "teeth are beautiful" for their theme of the week. One place this was to appear was on all milk bottle caps. More details on the Calgary projects are not available at this time but may be reported later.

The ADHA is considering undertaking an educational production, either one or a series, to be used on MEETA. MEETA (Metropolitan Edmonton Educational TV) officially began broadcasting on a regular TV network in March, 1970. All programs are entirely educational with no advertising and are aimed at the adult group (7-9 p.m.) as well as the pre-schooler and student. The initial need for programs should provide a good opportunity for the ADHA to do something new in attempting to educate the general public in dental health.

We are starting plans to host a Dental Hygiene section at the Western Dental Convention in The Licensing and Registration committee has been investigating and working on proposed legislation to govern the profession of Dental Hygiene in Alberta since 1967. It was definitely decided last spring NOT to be governed under the Dental Association by-laws but to work on a Dental Hygienists Act. Since this critical decision by us, a new health minister has been appointed and we are presently at a standstill. At this sitting of the legislature, a new act governing all professions will be introduced. How it will affect us we do not know but one thing is certain — we in the Dental Hygiene Association will be affected. Only when we see this new act will we know what the next step in controlling our profession will be.

FROM QUEBEC

In January of this year Quebec Dental Hygienists apted to form an association. Study gr sessions with guest speakers are held at six week intervals to help enlarge our scope knowledge.

Though our membership numbers only ten, by the fall we hope to initiate the follow projects:

- To establish a voluntary public service program which would saturate a particular dis with dental hygiene information;
- To lay the groundwork for a dental hygiene placement service;
- To plan a dental hygiene workshop day.

We are an enthusiastic group anxious to welcome new members. In our own way we trying to meet the problems of today and challenges of tomorrow in our role as der hygienists.

Mrs. Jueliann Jacobson R.D

DENTAL HYGIENE AT UBC

The future for dental hygiene at the University of British Columbia seems bright for seventies. Many interesting activities have been happening this past spring. One of the activi which the girls thought was a tremendous success was a box dinner put on by the practic hygienists of the Vancouver area. Here was an opportunity for future and practicing hygien to become acquainted.

The juniors have been in clinic for two months and we now appreciate all the hours we sp working on our "dummy" mandibles. The seniors have been having a tremendous respo from their teaching to school children. Next year there will be closed circuit TV, which will used as a teaching device in the classroom. This was the first year the dentistry building v open during OPEN HOUSE and the work which was done on these displays was excellent a well presented. With more people becoming aware of how important their teeth are, there possibility of more shining lights.

Miss Frances Laws



The Canadian Dental Hygiene

The Canadian Dental Hygienist

all, 1970



OFFICIAL PUBLICATION OF

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION

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TABLE OF CONTENTS

Editorial	
President's Report	
CPHA Recommended Qualification Requirements and Minimum Salaries for Public Health Dental Hygienists in Canada	
Fluoridation Statement	
Members of the Dental Health Division	
Demand for Hygienists Grows in Manitoba	
Convention 1970 Report	
Convention 1971	
A Word From the ODHS	
FDA Hits Ad Claims of Eight Dentifrices	
CFDE News	
Michigan Dental Association Meeting	
1970-1971 CDHA Officers, Delegates, and Committees	
Constitution Committee	
Editorial Committee	
Scholarship Committee	
Membership Committee	
Manpower and Utilization Committee	
Education and Recruitment Committee	
One Association Bans Smoking During Meetings	
Colonel Bhaskar Director of U.S. Army Dental Institute	
American Dental Association Shows Dental Health Improved	
New Books	
Positions Available	
Can We Help Our Colleagues?	
In Closing...a Smile	

INDEX TO ADVERTISERS

Block Drug Company	
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EDITORIAL

The Journal of the C.D.H.A. has a new editor. I certainly hope that my efforts in such a position are pleasing to you. I have no idea, however, unless helped or criticized. I need your letters.

The Journal should be as it says inside the front cover: "The Official Publication of the C.D.H.A." I want the Journal to be the voice of the Association — a unique medium through which our members and those from allied associations or professions can feel free to express opinions.

You will notice two new features in this issue entitled "Can we Help our leagues?" and "In Closing...a Smile" I cannot feasibly continue these columns unless you contribute to them. Don't wait until May to send these to me — send them while you think of them.

I hereby issue a formal invitation: Please contribute. I cannot effectively publish the Journal of the C.D.H.A. unless I have help from the C.D.H.A. If you cannot submit articles, write to me and tell me what articles you want to read. Then I will know what to search for to put into each issue. An editor is not supposed to put a Journal by herself — she should only organize what has been contributed.

I await your support.

Miss Jackie Sam

Ed

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PRESIDENT'S REPORT

Mrs. Sharon B. French (nee Amer) was appointed August, 1967 to the position of Senior Dental Hygienist as Consultant in Dental Hygiene, Dental Health Division, Department of National Health and Welfare in Ottawa, Ontario.

She received her B.A. in Sociology and Psychology at U.B.C., Vancouver, in 1963. In 1965, Sharon graduated with a B.S. in Dental Hygiene from Columbia University in New York. After instructing at the School of Dental Hygiene at the University of Alberta for 1965-1966, she received her M.S. in Dental Hygiene Education, Research, Public Health and Administration from Columbia.

Sharon is married to Dr. Hugh French, Assistant Professor in the Department of Geography, University of Ottawa. Her home town is Vancouver, British Columbia.

"Careers in Dental Hygiene"

The title of our Association's new dental health brochure "Careers in Dental Hygiene," with emphasis on the careers, is very pertinent to the times we live in.

Women are looking for "careers" in many new as well as old fields. Married women with a professional education are tending: to work longer, to continue to work through the first pregnancy, and with the first child, and to return to work after the children are a certain age. What does Dental Hygiene offer in the way of careers to these women or the men who are being welcomed into the profession now?

The career infers some type of progression upward or at least an opportunity for progression. A well-known Canadian sociologist made the comment that dental hygiene in Canada appears to have little career structure when compared to a well-polished allied health profession like nursing. By this he meant there was little opportunity for a hygienist to be promoted through the ranks to positions similar to a nurse or nursing supervisor. As the numbers grow in our Public Health sphere, hygienists should be willing and able by virtue of additional education and experience to assume roles of increasing responsibilities and duties in administration, supervision, consultation and research, as well as the more commonly talked about increased clinical duties. For a suggested career structure in Public Health, refer to the Canadian Public Health Association's recommendations. The data for the section entitled, "Dental Hygiene," were gathered and prepared in the Dental Health Division.

An increasing number of Dental Hygiene graduates are working towards their Bachelor's Degree. At present in Canada little credit is given towards a Bachelor's degree for the courses taken in the Dental Hygiene program; hence, the hygienist is starting almost completely again. Three, four or more years are needed to complete requirements. Taken part time or full time, it is a long struggle. As an Association, we should continue to press for credit to be given towards a degree for more of the courses taken in the Dental Hygiene program. We should support the development of Bachelor's Degree programs which build upon the basic professional education and prepare the Dental Hygiene graduate to assume more senior positions.

One approach is to have degree programs where the students who come from grade 12 or 13 take the Dental Hygiene and other courses in some co-ordinated combination. This succeeds in producing Dental Hygiene graduates with a degree but with no experience, who, after some suitable employment, should be able to assume increasingly more senior positions in the field of Dental Hygiene. However, as experience has shown in the United States, some of the graduates most likely will not contribute at these levels, due to preference, job location or retirement from the work force. To obtain a degree, this is to be expected.

As was stated earlier, there are many graduates from the present diploma Dental Hygiene programs, who desire to continue their education towards a Bachelor's Degree. Universities, particularly ones where Dental Hygiene schools already exist, should be encouraged to develop programs enabling these graduates with good grades, work experience and an interest in more senior positions, to obtain the necessary education on a full-time or part-time basis. Courses should be included on principles of teaching, experience of students of Dental Hygiene programs, curriculum development, analysis of clinical dental hygiene, general and dental public health, administration, with opportunities for further study in the dental specialties, for example, periodontology, and the biological and social sciences.

A highly successful program which prepares well-educated Dental Hygiene educators with varied work experience is the Columbia University Program B. Dental hygiene graduates, with above average grades, are admitted into the 2-year program terminating in a Bachelor's Degree. Courses are taken in such areas as the Sciences, Education, and Public Health. These courses are applied to special courses in such subjects as supervised teaching of clinical dental hygiene, dental hygiene curriculum development and administration of a dental hygiene program. The benefit of having finished a course in Dental Hygiene and having had some experience in practice, are found to be invaluable in the development of teaching skills. The Bachelor of Science program at Columbia offers a similar but more advanced program for dental hygienists with a degree for preparation for more senior positions. The student is able to contribute significantly to the courses and seminars and is able to gain deeper understanding when he or she has had some work experience. In our concern for the development of degree programs, we must accommodate these diploma graduate dental hygienists who want to upgrade their educational qualifications, and hence have a vested interest in playing a more senior role.

At the same time as we are looking at the development of a career structure and appropriate educational qualifications in Dental Hygiene, we are looking at the expansion of basic professional educational programs in post-secondary institutions which will be in satellite colleges or may be outside the university system.

Wise and careful planning with dental hygiene educators and practising dental hygienists involved in their evolution is needed. Each and every member of this association should make it his or her responsibility, and I stress responsibility, to become well-informed of the special needs, to offer assistance and to ask for representation of dental hygienists—as local practitioners and educators on planning committees. The time has come when we as dental hygienists must stand up and be counted as responsible and capable members of the community or accept what we are given.

The new Executive extends its best wishes for the coming year and encourages any member to feel free to write for advice, or to give comments or suggestions. We are at your service.

— Mrs. S.B. Freeman
President

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CPHA Recommended Qualification Requirements and Minimum Salaries for Public Health Dental Hygienists in Canada¹.

Prepared by Mrs. S.B. French

For the first time this CPHA Report² provides recommendations on four groups of Dental Hygienists. An extract of the Section entitled, "Dental Hygienists" appears below. For understanding of the complete text, refer to the Report³.

DENTAL HYGIENISTS

A questionnaire was distributed in the fall of 1969 through the directors of dental services in the provinces to public health agencies. Completed and returned questionnaires were identified as coming from six provinces leaving four provinces (Newfoundland, Nova Scotia, New Brunswick and Quebec) without identifiable returns. These replies covered an estimated 112 positions. Salary information was also obtained from the federal government.

In the grouping of positions and duties four groups are listed to cover the present and future development of dental hygiene positions in public health agencies.

In two provinces, Prince Edward Island and Saskatchewan, research projects are being conducted by the provincial departments of health utilizing dental auxiliaries with special training in limited restorative procedures under the direction and supervision of a dentist. In one project dental hygienists were given extra formal training, whereas in the second British trained Dental Auxiliaries or New Zealand trained Dental Nurses are being utilized. The extent of the training and duties varies from one project to the other.

In one of the provinces higher scales have been established for dental hygienists with this extra training and these duties than were in existence for the dental hygienists without this extra training. However, it is still too early to establish definite recommendations for duties and salaries for these special positions.

Group definitions and related recommended salary bands for dental hygienists for 1970 are set out below.

GROUP I

Position and duties: This group consists of staff hygienists employed in dental health education and preventive dental procedures under the direction of a full-time dental officer or a Group I dental hygienist. Persons in this group may be responsible for the supervision of a dental assistant or clerk.

Qualifications: Graduation from an approved school of dental hygiene and a qualification for registration by a provincial licensing authority.

Recommended salary scale: Minimum \$6,500 per annum, maximum \$8,500.

GROUP II

Position and duties: In addition to the duties of a Group I hygienist, a Group II hygienist should be capable of assuming supervisory responsibilities of staff hygienists, assistants and clerks and of assisting in the design, planning and implementation of programs. A Group II may be assistant to a Group III hygienist.

Qualifications: In addition to the requirements of Group I, a minimum of three years experience in a public health program or equivalent experience. Postgraduate training in subjects related directly to the responsibilities of the position would be desirable.

Recommended salary scale: Minimum \$8,000 per annum, maximum \$10,000.

Position and duties: In addition to the duties of a Group II hygienist, a Group III hygienist should be capable of assuming greater supervisory responsibilities over staff hygienists, assistants and clerks, and major responsibilities in the design, planning and implementation of programs. The population served might be greater than that of the Group II hygienist and the organization such as it requires increased responsibilities.

Qualifications: In addition to those required for Group II, a Baccalaureate degree in a subject related directly to the responsibilities of the position is required.

Recommended salary scale: Minimum \$10,000 per annum, maximum \$12,000.

GROUP IV

Position and duties: This group consists of senior or consultant dental hygienists at the federal or provincial level, or in a very large dental public health organization in a local department of health, who would be responsible to the senior dental officer in the organization. Duties might include the national and provincial consultants might include advising provincial and/or local departments of health, faculties of dentistry and schools of dental hygiene, professional associations at national and/or provincial and local levels as well as other organizations on the recruitment, training and employment of dental hygienists in public health agencies and private practice. Duties may also include supervision of staff dental hygienists within the province, or assisting in the development and maintenance of a federal or provincial dental health education program.

Qualifications: In addition to the requirements for a Group III hygienist, a master's degree in a directly related field and a minimum of three years experience in the field of dental hygiene.

Recommended salary scale: Minimum \$10,000 per annum.

1, 2, Extracts from the "Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada," Sixth Revision, 1970 Report Prepared by a Committee of the Canadian Public Health Association and Accepted by Council at its Meeting, Winnipeg, Manitoba, on 19 May, 1970.

2, 3 Available in French and English without charge from the Canadian Public Health Association, 1255 Yonge Street, Toronto 7, Ontario.

FLUORIDATION STATEMENT

The Honourable John Munro Minister of National Health and Welfare Canada. Released May 15, 1970 in commemoration of twenty-five years of fluoridation in Brantford, Ontario.

"Twenty-five years ago, on June 20, 1945, the City of Brantford, with a population of 35,000, was the first in Canada to initiate fluoridation of its municipal water supplies to improve the dental health of its citizens.

Today over 365 Canadian municipalities, with a population of more than six and a half million are enjoying the protection of fluoride-adjusted water systems.

I have on several previous occasions stated that my Department is satisfied that fluoridation of water supplies is the most important, practical and effective public health measure currently available for safely and economically reducing the incidence of dental caries.

I therefore advocate the widest, practicable implementation of this public health measure by the authorities responsible for communal water supplies in Canada."



Dr. R.A. Connor, Chief of the Dental Health Division Department of National Health and Welfare at his desk.

Photographs by Dept. NH & W, Canada

Dr. T.L. Marsh, Research Officer in the Dental Health Division checking over some dental health survey results.

Photograph by Dept. NH & W, Canada





Miss Ninfa-Anne Johnson, dental hygienist and Miss Barbara Scott, dental assistant, in training for the dental component of the Nutrition Canada survey team.



Mrs. Sharon B. French Consultant in Dental Hygiene in the Dental Health Division looking at one of the Department's dental health education publications.

Photograph by Dept. NH & W, Canada

DEMAND FOR HYGIENISTS GROWS IN MANITOBA.

To spur interest in the recruitment and employment of dental hygienists, staff and members of the University of Manitoba's graduating class in dental hygiene and officials of the Manitoba health department and the Western Manitoba Dental Association put on a special display of the role of the dental hygienist at the April 15 meeting of the WMDA in Brandon.

Emphasizing the growing demand for dental hygienists, the young women participated in demonstrations designed to illustrate the varied services a trained hygienist is capable of providing. C.H. McCormick, Manitoba's director of dental services, Marnie Forgay, director, School of Dental Hygiene, and D.K. Hurst, WMDA president, cooperated in the project.

Graduates demonstrate role

The three-pronged program stressed the value of hygienists' assistance in private practice, introduced career-minded young women to the role of the hygienist, and demonstrated to the young graduates that service in a smaller centre can be attractive and rewarding.

Following a tour of the Brandon hospital facilities and a visit to the local water treatment plant, where special attention is given the addition of fluorides to the water supply, two groups of hygienists conducted displays of their work.

One group, under the supervision of dentists in their own offices, treated actual patients and showed techniques in scaling and polishing. The second group, divided into seven teams, set up creative displays to demonstrate to the public the advantages of dental hygiene as a career for a young woman.

Scarce

Dental hygienists are scarce and so far the demand has far exceeded the supply. The 150 hygienists now graduating each year across Canada are im-

mediately absorbed in positions in public health, institutional work, group practice and private practice. Projected figures indicate that 10 years from now many as 2,000 young women may enter the dental hygiene field annually.

About 60 per cent of Manitoba's yearly graduates remain in the province to work, although openings are available throughout the continent, and also in some centres in Europe. A recent graduate of the two year diploma course is employed at Winnipeg Children's hospital, and another, whose second year of study was financed by a public health bursary, is an enthusiastic member of the staff of the Neepawa Health Unit. She is predominantly engaged in dental health education, lecturing education students, mothers and prenatal classes, but she works as well under the supervision of dentists in rural clinics.

Another dental hygienist working in public health in the Brandon-Virden Health Unit area graduated in 1958 from Ontario when hygienists were in very short supply. She finds public interest in the course increasing rapidly as more people become aware of the hygienist's role.

Opportunities unlimited

One of the rewarding aspects of dental public health work is closer contact with people at all levels of society, as hygienists point out. They also cite as an incentive, the opportunity of practising a profession for which there is a constant demand wherever they may choose to go. This makes it possible for those who prefer the small rural centres to find work there, while those who wish to settle in an urban area will likewise find plenty of scope.

Currently, the Manitoba government employs six dental hygienists. One is based in the Winnipeg central office of the Division of Dental Services, one is attached to the Mount Carmel Clinic and the remainder work in rural health units.



Above: Dental hygienists Evelyn Bachinsky, Gaylene Zackrisson, and Jane Chan demonstrate practical uses for dental health teaching aids.

Below: Members of the University of Manitoba's graduating class in dental hygiene visited the Brandon water fluoridation plant.

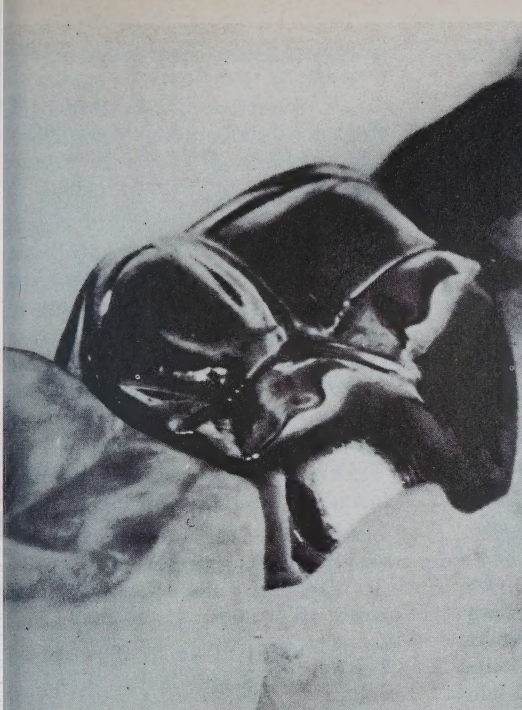




Above: J.T. Aills, Brandon, Manitoba, listens attentively while dental hygienists Janet Johnson and Barbara Burrows demonstrate the long cone radiographic technique.

Below: Brandon dentists inspect health education materials.





Confidence is a gold inlay with undetectable margins



Confidence is also knowing the dentifrice you recommend has repeatedly been *proven* beneficial to patients like yours. Crest has.

Crest is the only dentifrice offering proof of *extra* decay reduction[†] for individuals already protected by fluoridated water,¹ by fluoride topical and fluoride in the prophylaxis paste,² and by all three.³

Crest is unmatched in the weight of its published clinical evidence. It is the only leading dentifrice recognized effective by the Council on Dental Therapeutics of the American Dental Association.[†]

When you consider this record, it is apparent why you can have confidence in Crest.

(1) J.A.D.A. 73:853, 1966. (2) J.A.D.A. 75:1402, 1967. (3) J.A.D.A. 70:814, 1963.
*The control dentifrice was the Crest formula but without stannous fluoride and stannous pyrophosphate.
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Confidence is Crest

†Evaluations by the ADA Council on Dental Therapeutics are limited to dental products made in the U.S.
The Crest formula in Canada, however, is identical to the one used in the U.S.

CONVENTION 1970 REPORT:



The national convention of the Canadian Dental Hygienists' Association held in Winnipeg July 1st-4th appears to have been an all round success. Some 84 dental hygienists from across Canada registered. Several dental hygienists travelled from the Western United States including one of our guest speakers, Miss Margaret Ryan of Chicago.

The actual convention was preceded by a day and a half board meeting which ended up running into the wee hours of the morning.

The convention opened Wednesday evening with a registration party. Wine and cheese was followed by a most delightful variety concert.

Registration continued Thursday morning at which time the girls received program information and their favour kits. The surprises in each bag ranged from (would you believe) toothpaste to "Action" gum.

Things got off to a very interesting start Thursday morning with our first guest speaker, Miss Margaret Ryan — Director, Dental Hygiene Education — Council on Dental Education — American Dental Association. She was most interesting and enlightening, speaking to us on "Trends in Dental Hygiene Education."

Following Miss Ryan the girls attended a lecture by Dr. S.N. Bhaskar from Walter Reed Army Medical Center, Washington D.C. who spoke about "Periodontics General Practice."

A lovely luncheon, hosted by the Manitoba Dental Hygienists' Association was held in the Gold Room. Since this was our only formal luncheon, all fabulous door prizes were given out ranging from a water-pik to a stereo cassette tape player! Following lunch the C.D.H.A. held its annual general meeting, reporting to its members the highlights of the Board Meeting.

The remainder of the afternoon was taken up by table clinics. The C.D.H.A. was represented by six table clinics each of which was very well received.

The table clinics and their participants were:

1. "Dental Hygiene in Nova Scotia" — Mrs. Linda Zambolin, R.D.H., Nova Scotia.
2. "The Dental Hygienists' Assistant" — Miss Jackie Samson, R.D.H., Manitoba; Miss Adrienne Kalsey, R.D.H., Manitoba.
3. "The Role of the Dental Hygienist with the City Health Department" — Mrs. Rhonda Moray, R.D.H., Manitoba; Mrs. Judy Palansky, R.D.H., Manitoba.
4. "Flannel Fun in Dental Health" — Miss Delphy Tatebe, R.D.H., Alberta.
5. "Time, Motion and Economy as Related to the Dental Hygienist" — Miss Bonnie Craig, R.D.H., British Columbia; Mrs. Sandra Tucker, R.D.H., British Columbia.
6. "The Brush-In" — Miss Cathy Thompson, R.D.H., Ontario.

Friday we heard lectures from Mr. W.W. Shortill on "Utilization of the Dental Hygienist in Group Practice," and Dr. T.K. Barber, whose topic, "The Dental Hygienist takes a look at Herself" was both amusing and informative. There was also time on Friday to view the commercial exhibits and to relax for a few minutes in the Hygienists' Lounge.

Friday evening was fun and exciting. Hygienists and husbands or escorts. Cocktail party was followed by dinner at the Hollow Mug Theatre Restaurant. A sumptuous steak dinner and a deft music comedy was thoroughly enjoyed by all who attended.

Saturday morning we heard Dr. Golub speaking on the possible "Future Role of Dental Hygienists in the Diagnosis of Periodontal Disease." A most stimulating lecture on measuring the level of crevicular fluid, it left us all something to think about. The Canadian Dental Association's "Role of Allied Personnel in Canada" followed and wound up the scientific portion of the convention.

Anyone who attended W3 (Wild Wing Wind-Up) Saturday evening will agree that it was a smashing climax to a most enjoyable convention.

At this time I would like to thank the members of the Manitoba Dental Hygienists' Association and the Canadian Dental Hygienists' Association for the lovely corsage and C.D.H.A. pin presented to me. Also a special thank you to everyone who worked so diligently to make Convention '70 both knowledgeable and enjoyable.

Ken Wise, Convention Chairman, '70.

CONVENTION — 1971

Don't forget Convention '71! It's not soon to consider seeing Ottawa in summer. A warm welcome awaits you in Canada's Capital despite the fall chill.

In addition to a stimulating scientific programme, we will entertain you in elegance at Canada's beautiful National Arts Centre, and also with warm informality give you a chance to meet and to work with your fellow hygienists.

So wind your way to Ottawa for September 29th through October 2nd. Give us a chance to change the image of the profession!

Barbara Thom, Convention Chairman '71

A WORD FROM THE O.D.H.S.!

It is not a misprint. We do mean the O.D.H.S. What does it stand for? — the Ottawa Dental Hygienists' Society and this is its story.

In the summer of 1967 Ottawa boasted a total of four dental hygienists, each of us unaware of the others' presence in the city. This situation continued until the summer of 1968 when our numbers had nearly doubled.

In the fall of that year — largely through the efforts of Mrs. Ruth (Hewitt) Sword, who undertook to track down rumours of our existence and locate all of us — four of us finally met as a group. This first meeting was over lunch on a weekday in a restaurant close to our offices. The idea of being able to share the frustrations of practice that each of us had previously been dealing with in isolation proved so popular that we decided to meet again, over lunch, and to try to encourage the other girls, who had been unable to make this first meeting, to attend.

Our second luncheon attracted six people and it was decided that lunch hour was neither convenient nor long enough to satisfy the group's needs. Accordingly, an evening meeting was arranged at one of the girl's homes. This marked the beginning of regular monthly meetings, hosted in turn by each of the girls, which were to become a combination of group therapy "beefing" sessions and social gatherings.

By January 1969 our numbers had grown to eight and attendance at our meetings was stable. Mrs. Sharon (Amer) French suggested to us at this time that we organize and become a formal society and study club. However, general consensus of opinion was that a formal structure imposed on such a small number would prove discouraging because of the pressure on each individual member. Thus the group opted for the continuation of our informal programme.

During our summer recess we lost some of our original hygienists and gained others so that our number remained fairly constant. Upon reconvening in the fall, a copy of the suggested constitution for Constituent Societies of the O.D.H.A. was forwarded to Ruth Sword for our consideration and was again shelved for future reference.

Come January, with the change in the location of the C.D.A.-C.D.H.A. Convention for 1971 from Windsor to Ottawa, an appeal went out for a chairman from here. No one wanted the job without the assurance of solid support. This, plus rather disquieting news regarding dental hygiene in the government's report on the Commission on the Healing Arts, made us feel that perhaps an official corporate voice would be stronger than even consolidated personal opinions. Thus in March of this year we decided to form a constitution laid down by the O.D.H.A. for this purpose.

Our officers for this 1970-71 term are:

President — Miss Anita Langenholt

Secretary — Mrs. Maria (Limo)

McConkey

Treasurer — Mrs. Sylvia (Burtch)

French

We as a group (now numbering 12) look forward to arranging your 1971 Convention and to welcoming you to our city next fall.

F.D.A. HITS AD CLAIMS 8 DENTIFRICES

The Food and Drug Administration has issued a report stating that eight dentifrices did not live up to their claim of caries-prevention. The F.D.A. announced that it would begin action to rescind marketing approval of the eight brands as they are presently advertised. However, most, if not all, of the brands are no longer advertised or marketed.

The eight are: Brisk Activated Toothpaste, Colgate Chlorophyll Toothpaste with Gardol, Colgate Dental Cream with Gardol, Antizyme Toothpaste, Kolynos Fluoride Toothpaste, Super Amm-I-Dent and Amm-I-Dent Toothpaste and Powder.

The A.D.A. Council on Dental Therapeutics has reviewed periodically the clinical studies that have been conducted with dentifrices containing the active agents employed in these products and has reported to the public and to the dental profession that there was insufficient proof of their effectiveness. The F.D.A. reported that Crest with stannous fluoride and Colgate with monofluorophosphate had sufficient proof of effectiveness.

DE SCHOLARSHIPS FOR NTAL HYGIENE STUDENTS

TORONTO — Starting this year a Canadian Fund for Dental Education scholarship worth \$200 will be offered in each of Canada's five dental hygiene schools, it was recently announced by trustee James D. McLean, D.D.S.

Funds for the scholarships have been fully provided by the Procter & Gamble Company of Canada Ltd., the Canadian Dental Hygienists' Association and the Canadian Fund for Dental Education.

Dr. McLean said, eligibility terms of the scholarships drafted by the CDHA

1. Candidate must be enrolled in the second year of a dental hygiene course at an accredited Canadian school of dental hygiene.
2. Candidate must have achieved a high academic standard and have participated in organized undergraduate activities.
3. If there is more than one student fulfilling the above criteria the scholarship should be shared between them.

Scholarship winners are to be selected by the awards committee in each school.

Declared Dr. McLean: "This tangible encouragement for dental hygiene students is another important step forward in CFDE's continuing program of moving the industry up."

ANADIAN FUND FOR DENTAL EDUCATION MONTH

October is CFDE Month and for the first time hygienists as well as dentists will be asked to make tax deductible contributions to the Fund.

All gifts from hygienists will be used exclusively to increase the value or number of scholarships for dental hygiene students.

MICHIGAN DENTAL ASSOCIATION MEETING

Members of the "Canadian Dental Hygienists' Association" are cordially invited to participate in one of the nation's largest state dental annual meetings, the 114th Annual Meeting of the Michigan Dental Association. The meeting, with an attendance of more than 4,500, will be held April 18-21, 1971, at the Hilton Hotel in Detroit, Michigan.

Reservations are now being made for table clinics for the 1971 Annual Meeting. The table clinic activity is a highlight of the scientific program at the meeting, and those participating will have an unequalled opportunity to share knowledge and experience with a large and enthusiastic audience.

Registration as a table clinician for the 1971 Annual Meeting must be made early. Any dentist interested in participating in this program should contact, as soon as possible, Doctor W.W. Niemann, 228 Packard, Ann Arbor, Michigan 48104. Information on table clinic subject and equipment required should be included.

C.D.H.A. PINS AND CHARMS

C.D.H.A. pins and charms are available from our treasurer,

Mrs. Rosaleen Fedak,
#2-1167 Dover Cres.,
Ottawa 3, Ontario.

or from: Henry Birks and Sons (Man.) Ltd.
Portage Avenue at Smith Street,
Winnipeg 1, Manitoba.

Prices: \$6.95 for either pin or charm.

1970-1971 C.D.H.A.

OFFICERS, DELEGATES AND COMMITTEES

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(Ontario)

PAST-PRESIDENT: Mrs. Pat Johnson
(Ontario)

PRESIDENT-ELECT: Mrs. Linda Zambolin (Nova Scotia)

SECRETARY: Mrs. Ruth Sword (Ontario)

TREASURER: Mrs. Rosaleen Feduk
(Ontario)

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Mrs. Donna Anderson Man./Sask.

Miss Marlene Terada

..... Quebec (provisional delegate)

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Miss Bonnie Bryce Manitoba

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..... British Columbia/Sask.

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..... B.C./S

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Miss Norma Eyre, Chairman ... Alb

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Education and Recruitment:

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Chairman Mani

Mrs. Pat Johnson, Sub-committee

Chairman Ont

Mrs. Sharon Pitchford Ont

Mrs. Sharon Taylor Nova Sc

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Mrs. June Coe B.C./S

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Miss Cathy Thom Ont

1972 Chairman,

Mrs. Judiann Jacobson Que

Nominating:

Mrs. Linda Zambolin,

Chairman Nova Sc

Miss Joan LeBreton Ont

Miss Barbara Niehaus Alb

Mrs. Carolyn Fellows Nova Sc

Mrs. Karen Hyman Mani

Mrs. Lillian McKittrick B.C./S

Executive Appointments:

Miss Jackie Samson, Editor .. Mani

BUSINESS RELATING TO THE CONSTITUTION COMMITTEE

The operating procedures relating to committee have been amended and fully will facilitate earlier approval of constituent constitutions. It should also be noted that a procedure for "Mail voting" can now be used to enable voting of constitutions at a time other than a Board meeting. Other association business can be conducted by "Mail vote" also. This was resolved because of the widespread nature of the Board of Directors and because of the urgency of the business presented to the Executive Committee. The Secretary of the N.S.D.H.A. is to be responsible for sending ballot and a full description of the issues involved to the delegate or the alternate delegate if the delegate is unavailable at least two weeks prior to the date of the vote. The decision of the motion rests on a majority count of returned ballots. The vote is to be considered valid only when at least two-thirds of the ballots are returned and are mailed. A majority count shall be two-thirds of the returned ballots.

Alberta — Proposed amendments to the N.S.D.H.A. constitution will be reviewed by the Board of Directors for a mail ballot.

British Columbia — Proposed constitution will be given top priority.

Ontario — O.D.H.A. amended constitution has been approved.

Manitoba — M.D.H.A. was encouraged to submit a copy of the amended constitution to the Constitution Committee when available.

Saskatchewan — The C.D.H.A. now has six constituent associations with the approval of the S.D.H.A. amended constitution. We welcome them.

Alberta —

British Columbia

A.D.H.A. constitution is to be returned to them for review.

Constitution is to be circulated for approval to the Board of Directors for a mail ballot.

BUSINESS RELATING TO THE EDITORIAL COMMITTEE

It has been recommended that a mailing address of 234 St. George Street, Toronto 180, Ontario be adopted with regards to general mailing for the Journal. The envelopes are to be marked "Attention Editor". These will in turn be forwarded to the current editor.

In future the Journal issues will be mailed to members as first class mail since they are not forwarded when sent as second class mail.

Extra Journals will be printed beyond the subscription and membership number to allow for current Journals to be included in the membership kits to all new members, new subscribers, advertisers, and to allow for file copies. Consultation with the membership chairman shall determine the number needed.

BUSINESS RELATING TO THE SCHOLARSHIP COMMITTEE

It has been recommended that the name of the scholarships be as follows: "C.F.D.A. Scholarships for Dental Hygienists, co-sponsored by the C.D.H.A., the C.D.F.A., and the Procter and Gamble Company." There will be five awards of \$200.00 each, one for each existing dental hygiene school. The C.D.H.A. will notify the existing schools of the availability of these scholarships.

To qualify for these scholarships it is no longer necessary to complete the first year of the Dental Hygiene Course in one year. A student may still qualify even if she has written supplemental examinations. Also, it is no longer necessary that the candidate be an active junior member of the C.D.H.A.

BUSINESS RELATING TO THE MEMBERSHIP COMMITTEE

The Board of Directors has decided to retain the \$5.00 reinstatement fee. The constituent associations were encouraged to familiarize their members with this policy and to assist members to comply with it.

Any active member who does not pay dues for the current year by January 31 and has not withdrawn by written resignation to the Constituent Membership Chairman shall have forfeited her membership.

If the member moves to another province she may request a transfer of membership to the Constituency to which she moves following resignation of membership from the Constituency from which she has moved. If she resigns because of a move and does not wish to transfer membership to another Constituency the member is considered withdrawn and is not subject to a reinstatement fee. It was recommended to the membership chairmen of the constituent associations that provision be made for withdrawal of membership on the membership forms. An associate member may request a transfer to active membership upon notification of the Canadian chairman. She may become an active C.D.H.A. member with no additional payment of fees for the current year.

It should be the responsibility of the membership chairman in the constituency from which the member is leaving to furnish proof that the particular member is in good standing and has asked for transfer of membership.

It has been decided to give members something tangible besides a receipt the first time they take out membership in the Association. This will be in the form of a membership kit. The Constituent Associations could add or delete to make the kit as applicable and worthwhile as possible for their membership. The Membership

Committee is authorized to proceed with the development of a membership kit to be given to new junior active and associate members of the association. It is recommended that this kit be financed jointly by the C.D.H.A. and the constituent associations. They shall include C.D.H.A. material and pertinent constituent association information and material.

BUSINESS RELATING TO THE MANPOWER AND UTILIZATION COMMITTEE

Each provincial association should strive for representation on provincial dental governing bodies responsible for dental hygiene. The establishment of a dental liaison board has been approved. Nova Scotia was the first to establish such a board. If we are to advance the professional cause and protect the public, to overcome the lack of communication between various dental and dental hygiene associations must be corrected.

It has been recommended that the C.D.A. co-operate with the C.D.H.A. in the investigation of the utilization of dental auxiliaries. As increased use of auxiliaries seems certain in the near future the creation of many more auxiliaries would seem futile unless those who are directing them are fully aware of their capabilities and the means of utilizing them to the fullest. This recommendation has been referred to the C.D.H.A. Dental Auxiliary Services Committee for consideration. The C.D.H.A. offers assistance in this investigation.

Business Relating to the Education and Recruitment Committee

Recommendations for the 1970-1971 committee:

The C.D.A. Council on Education recommended that advisory or liaison committees be organized to collaborate with educational institutions developing dental hygiene courses. A dental hygiene representative shall hold a position on the committees; she shall be thoroughly familiar with the situation and be able to discuss any problem that may be encountered. The Education and Recruitment Committee of the C.D.H.A. should immediately develop a set of guidelines to prepare a hygienist to serve on an advisory committee for the purpose of establishing future dental hygiene courses.

A policy for continuing education should be formed and concrete recommendations and ideas for initiating projects should be drawn up.

The Board of Directors also recommends that career pamphlets be circulated through school guidance counselors by consent association committees as an improved means of distribution of the career pamphlet. The Education and Recruitment Committee Chairman should check with the federal government re: information on Dental Hygiene career available through guidance counselors and other sources for career information as well and if necessary proceed with formulating a new pamphlet with suggestions brought to the next board meeting.

The duties of the Education and Recruitment Committee have increased greatly this past year and the importance of these duties is such that it must be insured that each function is given adequate study and development by the committee members. It has been suggested therefore that either the committee be divided into two separate committees or that at least

one sub-committee be appointed to undertake responsibility for assessing and developing educational programs — undergraduate, post-graduate, continuing education, refresher courses, retraining courses, in the event of the expansion of duties.

The following has been paraphrased from the A.D.H.A. Dental Hygiene Liaison Committee and has been adopted as C.D.H.A. policy: Re: Dental Hygiene Manpower — The C.D.H.A. could play a leading role in urging the provincial dental boards, the provincial dental associations and local dental associations, and the provincial dental hygiene association to encourage the non-practising dental hygienists to return to active practices and that the above agencies co-operate at the local level in the development of refresher and continuing education courses which would ensure that hygienists who have been out of practice for a considerable length of time have the mechanism to elevate their skills to current standards.

ONE ASSOCIATION BANS SMOKING DURING MEETINGS

In what is believed to be an unprecedented action, the Colorado Dental Association has prohibited smoking during its official sessions.

It was resolved that the Association, being fully cognizant of the danger to health associated with smoking, urges its members to undertake an educational program to inform their patients of the hazards, both oral and systemic, associated with the use of tobacco. Special emphasis should be placed on young people, to warn them against the dangerous habit of smoking tobacco. Strong support has been given to anti-smoking legislation calling for the banning of cigarette, cigar, and pipe advertising in newspapers and on television and radio.

As evidence of their sincerity associated with the foregoing resolution related to the health hazards associated with smoking, The House of Delegates prohibits smoking during its official sessions.

COLONEL BHASKAR DIRECTOR OF U.S. ARMY DENTAL INSTITUTE

Colonel S.N. Bhaskar has been appointed as the Director of the U.S. Army Institute of Dental Research located at the Walter Reed Army Medical Center in Washington, D.C. The Army Dental Institute is the only organization of its kind and is devoted exclusively to military Dental Research and Education. Seven one week courses in various aspects of dental practice are given every year and these are attended by military as well as by more than 1,500 civilian dentists.

Colonel S.N. Bhaskar received D.D.S. from the Northwestern University and M.S. and Ph.D. degrees from the University of Illinois. He is a diplomat of the American Board of Oral Pathology and the American Board of Oral Medicine. He has published more than 140 scientific papers and contributed to 5 books. In addition, he is the sole author of 3 text books which are used in most dental schools in the United States and Canada.

Any member of the American Dental Association interested in attending one of the scientific courses offered at the Institute is invited to write to the Director.

AMERICAN DENTAL ASSOCIATION SHOWS DENTAL HEALTH IMPROVING

The United States may be winning the battle against tooth decay. A nationwide survey of dental services was published in the July issue of the *Journal of the A.D.A.* The survey was conducted during 1969 and disclosed that "significant changes have occurred in the proportion of patients receiving various services since similar surveys were conducted in 1959 and 1950." The survey involved 35,793 patients and 2,953 dentists.

The percentage of patients receiving extractions, fillings, and dentures declined. An increase occurred in the percentage of patients receiving prophylaxis, radiographic examinations, fluoride treatments, orthodontic care, crowns, fixed bridges and root canal treatments.

Science Editor Arthur Snider of the *Chicago Daily News* has written: "For the first time since the nation's founding, dentists may be getting on top of the crippled-tooth crisis. For 200 years, the mouth has been a U.S. disaster area. More than 95% of the Americans have been afflicted with decay, the most prevalent of all chronic diseases. Hitherto the dental office has been a repair shop, but now it appears the corner has been turned."

Science Editor Ronald Kotulak of **Chicago Tribune** has noted that dentists are finding fewer cavities, they are extracting fewer teeth, they are providing fewer dentures and they are finding fewer cases of periodontal disease. There is very concrete evidence that preventive dentistry pays off. This is an important step toward the eventual goal of having dentists keep all their natural teeth throughout their lives.

NEW BOOKS

DENTAL SCIENCE HANDBOOK

Edited by Lon W. Morrey, D.D.S., Emeritus of the American Dental Association, and Robert J. Nelsen, D.D.S., former Chief of the Collaborative Research Program of the National Institute of Dental Research.

This is unquestionably the finest work available for satellite health services and has tremendous potential as a tool for patient education. This book will be a valuable addition to every dental waiting room.

The need for an accurate, simple yet sophisticated manual of dental science for people in other disciplines has been met in **Dental Science Handbook**. The illustrations, which are an integral part of each page, include 200 original drawings specifically planned to give the reader a clear visualization of the structure, processes, and conditions described.

Intended primarily for non-dentists, **Dental Science Handbook** presents an accurate and appropriate coverage of the biological and physical aspects of dental science, dental therapy procedures, health care programs and the organization and delivery of dental care through private practice.

The subjects selected are those which will most easily, quickly, and accurately present a wide spectrum of dentistry and be most useful to interested individuals whose special training has been in other professions.

This work will also be helpful to dental students, dental hygienists and dental assistants.

Dental Science Handbook, containing 311 pages, 324 illustrations, 116 tables, is paperback and sells for \$2.75. Available only from the U.S. Government Printing Office, Washington, D.C.

DENTAL X-RAY PROTECTION

Published by the National Council on Radiation Protection and Measurements. The booklet contains recommendations of the Council on Dental X-Rays and is available at \$1.50 a copy from NCRP Publications, P.O. Box 4867, Washington, D.C. 20008.

CO-ORDINATOR—DENTAL ASSISTING COURSE

Fanshawe College of Applied Arts and Technology, London, Ontario.

Invites applications for the position of Co-ordinator for this new program. The successful applicant will have an interest in students, a desire and ability to teach, administrative skills, and a high standard of interest in the profession.

Commencing Date—November 1, 1970 or as close to that time as possible.

Qualifications — Certification as a Dental Hygienist.

Experience—A minimum of two years professional practice. Teaching experience will be an asset.

Salary — Commensurate with experience. Please direct inquiries to: Milton Orris, Chairman, Health and Welfare Division, Fanshawe College, Box 4005, Terminal C, London, Ontario.

HYGIENIST WANTED

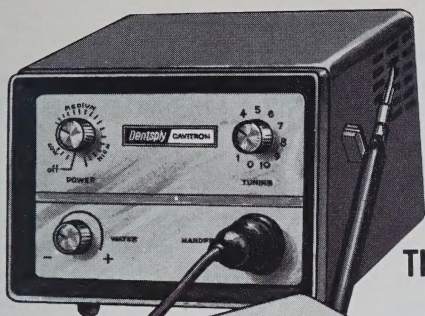
Opportunity exists for a full-time keen dental hygienist in a new and exciting community dental health program in Kelowna.

Salary ranging from \$575-605 to start. Generous mileage, meals laundry allowance and holidays with pay provide increased financial benefits.

Programs are different and futuristic —light years away from washing fluoride solutions over teeth.

Interested, enthusiastic hygienist contact:

Dr. A.S. Gray
Regional Dental Consultant
Okanagan Dental Health Centre
1143 Sutherland Avenue
Kelowna, B.C.



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THE DENTSPLY® CAVITRON® '1010'
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**You may prefer one
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Both Cavitron units operate with the extraordinary gentleness patients appreciate. They tell others. In fact, you'll probably never use another piece of equipment that brings as many referrals and does as much to build a practice.

Not to mention what a Cavitron unit will do for you. In lightening your work load. Making prophylaxis easier and faster. Saving extra hours of valuable time every month to treat more patients.

Both Cavitron units use the same inserts. The all new transistorized "1010" has automatic tuning, instant-on circuitry and automatic handpiece retraction. The "660" is the Cavitron unit now being used in more than one-third of all dental offices. The "660" is a slightly more moderate investment. Both are great investments. Thousands of dentists and hygienists consider them must investments.

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Equipment**

Dentsply International, York, Pennsylvania

CAN WE HELP OUR COLLEAGUES?

During our years of practice, we will often come across a new method, or a shortcut to do our routine procedures. Why keep these to ourselves? Other hygienists could benefit from your ingenuity. This column will be a regular feature, so please submit your suggestions to the editor. Here are some that have been collected from various sources:

1. Use a cotton roll or gauze square in the vestibule to clear the area for easier scaling on the labial of the mandibular anteriors.
2. Use the air syringe to locate calculus in deep pockets.
3. Swab on peroxide or iodine to bleach out green stain. Follow with "Zircate" or pumice.
4. Start with an anterior periapical film on children who are a little frightened of the X-ray machine. Once they are familiar with one X-ray, it will be easier to take bite-wing films.
5. Give your pedodontic patients a ring or a small toy at the close of the appointment. It will provide them with a pleasant recollection of the visit.
6. To see your operatory as the patient sees it, sit in your chair occasionally and look around.
7. Lingering cooking odours of onion or garlic on your hands can be removed by rubbing them with fresh lemon juice or washing with salt.

IN CLOSING... A SMILE

"Out of the mouth of babes ... Don't some children innocently say the funniest things? Here are just a few that I have collected over the past years. You are invited to submit your funnier collections. Let's all get a smile out of them.

"Watch my front tooth!"

Hyg: Which one?

"The one that isn't there!"

Hyg: Do you like your teacher this year?

"Yeah, but she's real old"

Hyg: How old do you think she is?

"Oh, at least 24!"

Hyg: How old are you?

"Five"

Hyg: When will you be six?

"I don't know, maybe after my next birthday"

"Look, lady! You have a hole in your leotard!!"

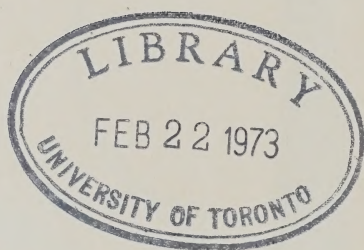
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The Canadian Dental Hygienist



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TABLE OF CONTENTS

Editorial	
President's Message	
Dental Hygienists and The Expanded Function Concept	
Poster Contest	
Expanded Duties for Supervised Auxiliaries	
P.E.I. Manpower Study Progress	
Oral Hygiene for Adolescents	
Taking Impressions for Young Children Who Gag	
Genetic Aspects of Dentinogenesis Imperfecta	
Statement by the Honourable John Munro	
Waterloo-Wellington Dental Hygienists' Society	
Association of Public Health Auxiliaries of Ontario	
A Report on the Dental Auxiliaries Service Committee (Man.)	
A Message from the Membership Chairman	
Missing Persons	
D.H.S. is Catching	
Information Regarding Requirements for B.C. Registration	
The 1971 National Convention	
C.F.D.E. Scholarship Winners	
Something New in Dental Hygiene at Dalhousie	
Fluoridation: Still an Urgent Need	
Synopsis of Continuing Education Course	
Guardians of the Smile	
Dental Costs Cut	
Positions Available	
Can We Help Our Colleagues?	
In Closing ... A Smile	

INDEX TO ADVERTISERS

Block Drug Company	O.B.C.
Dentsply International	
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THE CANDIAN DENTAL HYGIENISTS' ASSOCIATION

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EXECUTIVE

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EDITORIAL

Some time ago, a former chairman of the Royal Commission on Health Services had commented at an Ontario Public Health Association convention that "sending a girl to university for two years to become a dental hygienist to perform simple procedures is a waste of time when the same girl in a two year period can be trained to do fillings and handle current equipment just as well as a man." During this period of questioning and acute dental need, a survey of dental hygiene in Canada was conducted to learn some urgent facts regarding dental hygienists and the services they perform across Canada.

What did hygienists across Canada actually do to perform a health service for their patients? Here are some of the results.

Questionnaires were mailed to each hygienist in Canada with the 186 returning bringing the response average to better than 50 per cent.

Fifty-nine per cent received their two-year education from the University of Toronto and most girls were between the ages of twenty and twenty-four. The reasons for becoming hygienists were that they liked working with people, they were influenced by dental personnel or that they had been previously employed in some other aspect of dental work. Others liked the salary, working conditions and the hours.

Private, general practice employed the majority of the girls. Several were in paedodontic practices, nine in periodontic practices, three with orthodontists, and only one each in oral surgery and prosthodontics.

Very few hygienists were paid salary plus commission; the majority were on salary only, with a range from \$4,000 to \$6,000 per annum, average two years experience.

Only two-thirds of the respondents worked in the same office as their supervising dentist, while some reported that they worked up to 200 miles away!

The actual functions of the dental hygienist in Canada were of particular importance, since it was for this that her position was challenged. Prophylaxis was the main function, though the numbers performed per week ranged from 1 to 7. In conjunction, other major duties were to expose radiographs, process and mount them; hygienists also charted mouths and trimmed and polished restorations. Seventy-five per cent of the respondents indicated that they thought that Canadian dental needs could be more completely met by expanding the duties of the dental hygienist.

The fees charged for an adult prophylaxis were between \$5.00 and \$10.00, with a child's between \$3.00 and \$6.00. An extra of about \$2.00 was charged for a fluoride application.

This Survey was conducted in 1965. Has dental hygiene changed for the better since that time? Are Canada's dental needs being adequately cared for? What great improvements have occurred in the past six years?

Since 1965, several pilot projects have been undertaken to expand the duties of the dental hygienist. A report on one of these appears in this issue. Several committees have been formed to investigate the worth of the dental hygienist as she is trained today. A comment on these also appears.

For a more detailed report on The 1965 Survey of Dental Hygiene in Canada, adding the statistics, you may write to the person who conducted it. Miss Dixie Scoles, at that time affiliated with the University of Manitoba, developed the questionnaire with the assistance of Mrs. Phyllis Thompson, secretary, School of Dental Hygiene, Mrs. Vivian (Kereliuk) Burdeniuk, a student dental hygienist, and J.R. Trott, Professor of Oral Pathology, University of Manitoba, through whose department the printing of the questionnaire and the punching of the IBM cards were obtained.

Miss Scoles has worked many hours on this survey and your comments and inquiries are welcomed. You may write to her at:

Miss Dixie C. Scoles, Asst. Prof.,
Dental Auxiliary Teacher Education,
School of Dentistry,
University of North Carolina,
Chapel Hill, North Carolina,
U.S.A. 27514.

Jackie Samson, Editor.

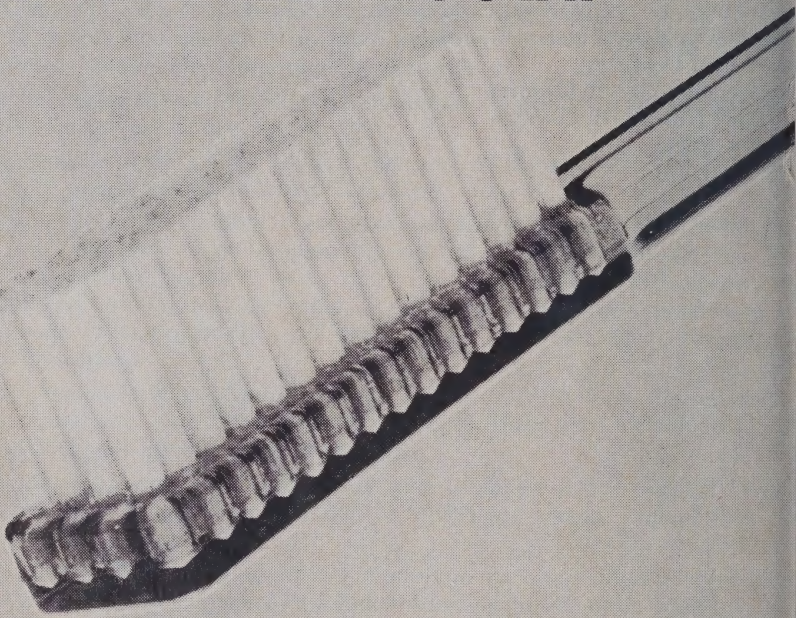
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President's Message

DENTAL HYGIENE: NEW DIMENSIONS

With all the talk about expanded duties for allied health personnel in Canada, physician-assistant, it is difficult for one to keep his feet on the ground and to maintain one's perspective. Perhaps this is good, though. We certainly are undergoing a prolonged period of critical self-analysis. Let us hope that when the pres-flurry of reports, opinions, discussions concerning that ominous jargon which s off the tongue with such ease "expanded duties for dental auxiliaries" and alth care delivery systems" dies down, we will not find ourselves standing in same spot. Let us hope that we have indeed inched just a little closer to that pia of providing a basic level of good dental health education and care to alladians.

After more than a couple of years in the making, the Report of the **Ad Hoc nmittee on Dental Auxiliaries** (Chairman: Chief Justice Dalton C. Wells), was ounced to the House of Commons February 22, 1971. You may not agree with the recommendations, but read it. As a professional person it is imperative that h and every member become fully aware of — not only its conclusions — but more ortant — its reasoning. Read it all. If you haven't your own personal copy of the ort, you may be able to obtain a copy by writing to Dr. R.A. Connor, Chief, ntal Health Division, Department of National Health and Welfare, Ottawa.

Another recommended reading is the article entitled, "Will Dental Hygienists Become Obsolete?", by Anna M. Barish and Nathaniel H. Barish, J.A.D.E. February, 1971, pp. 47-49. It is a most thought-and-action-provoking article. To obtain the fullest understanding, one must read the entire article, however, to quote just their recommendations for action to stimulate your curiosity to read the full text.

"... More and more of the functions of the hygienist will be assumed by dentists until she will become obsolescent — if not obsolete."

It is not too late to assure that the registered dental hygienist be retained an important professional in the delivery of complete oral health care. However, aggressive steps must be taken. Among them would be:

1. A statement by the American Dental Hygienists' Association, not only listing the expanded duties of hygienists but requesting the cooperation of the American Dental Association in setting up proper training programs.
2. A drive by the various state dental hygienists associations, in cooperation with local dental societies, to have the practice acts of their states amended so as to permit hygienists to perform these expanded duties.
3. Efforts by individual hygienists to get the cooperation and support of their employers along these lines.
4. Maximum ethical publicity by the various professional groups, so that dentists and hygienists will recognize the need and importance of training along these lines.
5. A drive by the national and local dental hygiene groups to persuade schools and departments to change their curricula so as to include these expanded clinical functions."

What is your view? What are your recommendations for action?

Convention 1971 — the national — in September-October, 1971, has been planned to provide you with a program for stimulating discussion on several of the horizons in Dental Hygiene. Please come, we need **you** and invite any dental assistants and technicians, too. Via their associations, CDHA has offered an invitation to all the dental team to share our scientific program. Read up beforehand. Prepare some good questions to ask of our invited guests and some recommendations to make for our association.

Our future in Dental Hygiene never looked better, nor our horizons more varied. Why not share in these exciting new developments?

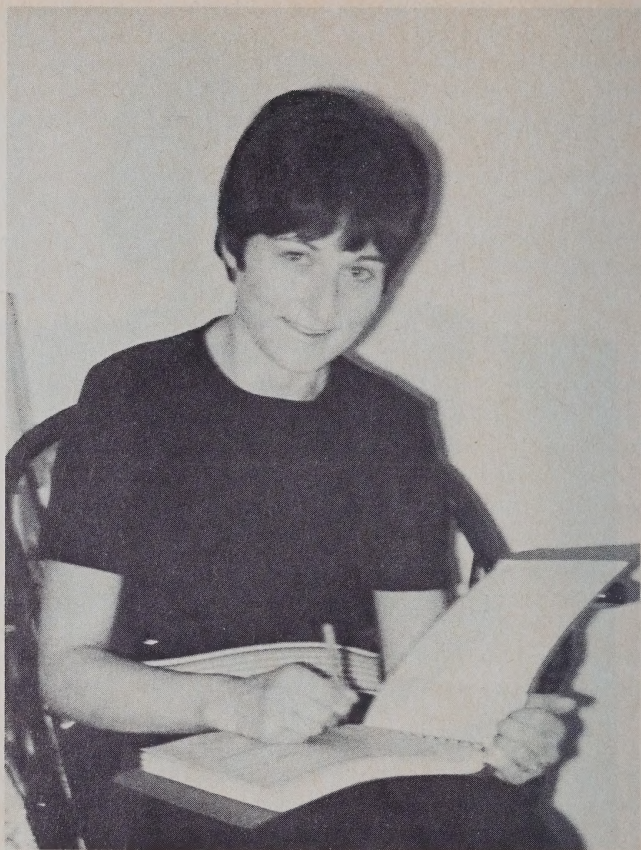
The Executive

It is often difficult to envisage or appreciate those in elected office who are working so dedicatedly for you. Let me introduce you to some of your CDHA officers.



Ms. Ruth Sword, Secretary of the CDHA, R.R. #1, Richmond, Ontario.

Ruth has the demanding task of handling much of the CDHA correspondence both inside and outside the association. This position requires a good knowledge of the Association's policies, files and committees. Many hours a week are devoted by Ruth to this behind-the-scenes work. As a conscientious and diligent worker who is also a wife, mother-to-be and up to a few weeks ago a practising dentist of several years private practice experience, we should all be proud to have a secretary like Ruth.



Mrs. Rosaleen Fedak, Treasurer of the CDHA, Apt. #2, 1167 Dover Crescent, Toronto, Ontario, Postal Code K1Z 7X3.

Rosaleen is our officer dealing in "high finance." We have almost 600 members in all categories and Rosaleen receives fees for each of these members via the constituent (provincial) associations. Keeping the budget of each committee and of the association straight, receiving cheques and bills regarding CDHA business, writing cheques, covering varied expenditures from coast to coast, and periodic consultations with professional auditors, are all part of the day-to-day "unpaid" duties of our "calculating" treasurer. Rosaleen just has to be efficient and management-oriented to manage so well being a wife, mother of a young son, regional public health officer and CDHA treasurer.



Linda Zambolin, President-Elect of the CDHA, Apt. #218, 25 Leaman Drive, Dartmouth, Nova Scotia.

Linda graduated from Dalhousie School of Dental Hygiene in 1966 and has been in private practice both in Victoria, B.C., and Dartmouth, since 1966. Linda brings a host of qualifications with her to the position of President-Elect for 1970-71 and President for 1971-72. During 1967-68, she was Chairman of the Nova Scotia Dental Hygienists' Association's Dental Health Committee. The following year 1968-69, Linda chaired the CDHA Education and Recruitment Committee. From President of NSDHA in 1969-70 and N.S. Delegate to the CDHA Board of Directors, she was elected to take our highest position and became President-Elect with the automatic progression to the Presidency in the fall of 1971 at our annual meeting here in Dartmouth. Linda is our "lady-in-waiting" so to speak, however, this is not as simple as it might appear. Linda is an active member of the Executive Council which, along with the Board of Directors, helps to make the policy decisions which govern the conduct of the CDHA. She receives copies of all correspondence by the President and gives her counsel on matters of mutual concern. Much time is needed to prepare mentally, physically and philosophically for the year as "President."

Mrs. Pat Johnson, Immediate Past-President of the CDHA (not shown), 8100 Midfield Road, Islington, Ontario, is the fifth member of the Executive Council. Her thorough knowledge of the workings of CDHA has been a continuing source of guidance to all in the CDHA. One of our greatest wealths as an Association are our Past Presidents who see a need somewhere while in office and aptly continue to serve the Association in this new found position. Pat's present projects are continuing Education and Advisors for Dental Hygiene Education.

Wouldn't you like to do something for CDHA and yourself, too?

— Mrs. Sharon French
President.

DENTAL HYGIENISTS AND THE EXPANDED FUNCTION CONCEPT IN SCHOOL DENTAL PROGRAMS

By Dr. W.C. King, Director of Dental Public Health, Nova Scotia.

Because of the population distribution in Canada no one method for delivering dental service would be suitable for all areas; however, it is probable that a dental team approach, consisting of a supervising dentist using trained operating auxiliaries, can provide dental services of a high quality on a more economical basis to larger numbers of people. This concept would apply particularly to the field of public health activity. As comprehensive dental care is expensive, the economical aspect is one factor to be considered when designing any health delivery system.

The prevalence of the three most common dental diseases, viz. dental caries, periodontal disease and malocclusion among the pre-school and school children at least in certain areas presents a major public health problem, and indicates the presence of gross dental neglect which is directly related to the lack of available preventive, educational and treatment services.

"The provision of an increased volume of dental service, especially for children, is a major problem, and its solution, in part, lies in the training of individuals who can work under the direction of a dentist."⁶

There presently exists an insufficient number of dentists to cope with the population's demands for dental care; neither will the projected increases in the number of dental graduates be sufficient. "Quite obviously, the supply of dentists and demand for service will be out of balance. The answer to this inevitable problem is an expanded use of dental auxiliaries."¹⁴

The direct costs of dental education, the length of training, the costs of providing additional well equipped and staffed physical facilities as well as competition from other disciplines for suitable candidates will all tend to compound the present deficiency of dental professional manpower.

It is therefore recognized by many dental authorities that special attention needed to solve the dental health problem. The future will undoubtedly bring changes in dental health care delivery from the present system, which is essentially of the solo practice type is inadequate. It is also an uneconomic method of production. Efficiency and economy to a great extent, cause a transition from solo to the team type practice where dentists and auxiliaries will be better able to provide quality dental care to more people on a more economical basis.

In order to solve the manpower problem the dental profession will have to make greater use of their professional training and skills by utilizing more auxiliary personnel with expanded functions in a supervised team approach to treatment.

It will be necessary for the dentist to be relieved of performing certain routine treatments and thus be able to give more attention to those physiologic, pathological and biochemical procedures which demand his expertise. Certainly without the assistance of well trained auxiliary personnel the dental profession cannot hope to give the best possible care to the whole population.

There is a need, of course, not only for more treatment, but for more research in preventive methods to reduce treatment requirements, if the population is to become even relatively free from dental disease.

The Nova Scotia Provincial Department of Public Health is presently planning a pilot project for dental auxiliaries utilizing the expanded duty concept.

is postulated that a dental hygienist be adequately trained in a period of two calendar years to perform implant restorative procedures for patients, in addition to her traditional restorative and preventive duties.

The hygienists have been chosen because they represent a licensed auxiliary profession which forms part of the dental profession; also because a two year formal training program for this particular discipline is already in existence. As the present curriculum includes training in basic and clinical sciences it would appear that the dental hygienist is the logical candidate for training in extended duties. She is also more likely to gain public and professional acceptance than any other auxiliary.

It would of course be illogical to impose additional duties on a present auxiliary if it were felt that the resources of the group were being fully utilized; however, it would appear that the dental hygienist resources have not been utilized to their full potential.

If hygienists are to be confined to their original role for which they were trained and which still remains their primary function, prophylactic treatment, the present two year course should be speedily reduced. . . .¹² "In view of the limited facilities for training hygienists, it would seem that urgent consideration should be given to shortening the training period for dental hygienists. The objective is that consideration be given to widening the scope of their training, to making appropriate amendments to the Dentistry Act to permit a wider range of services to be performed by hygienists."⁹

To introduce a completely new auxiliary at this time would tend to create increased resistance to the expanded function concept. It would also introduce new problems in the areas of training space, insurance, curriculum and teaching staff. It is realized that suggestions have been made to have a new auxiliary trained in the area of operative dentistry while the dental hygienist be given additional

training for increased function in the area of periodontics. It has also been suggested that the dental hygienist be trained to perform additional functions both in the restorative and periodontal areas. While these various suggestions have merit, the important point remains that there is a need for some form of operating auxiliary to become involved in a school dental program and in view of her training in educational and preventive procedures it would appear logical to add a very restricted area of restorative dentistry to her present training program, through a slight extension in training time and accept the dental hygienist as the most logical choice.

"The insistent dissatisfactions of dental hygiene organizations indicate that pressures will be brought to bear on the profession to have the dental hygienist effectuate a number of procedures in addition to those she may legally accomplish at the present time. There have been suggestions that she perform routine operative procedures, . . . and render needed periodontal care."¹⁶

It is also realized that there will be appreciable opposition from members of the dental profession to the recommendation that hygienists be trained to perform treatment procedures, since it may be argued that any involvement with treatment will reduce their effectiveness in prevention. Certainly no member of the dental team is more highly motivated in preventive concepts than dental hygienists and there is little reason to believe that this approach will change particularly in a public children's dental program where there is less reason to place emphasis on the number of treatment units completed.

G. H. Leatherman, secretary general of the Federation Dentaire Internationale recently stated, "There is no doubt in my mind that the dental hygienist must be prepared for her duties to be expanded. The international dental profession, in an effort to relieve its manpower problem, is finding a need for the

operating auxiliary, and the restricted duties of the dental hygienist, in relation to the wider curriculum of the New Zealand type of dental nurse, do not prove a satisfactory answer..."⁸

Using a team approach this proposed operating auxiliary would be employed in a government-sponsored children's program to carry out educational, preventive and limited treatment in the mouth, under the prescription and supervision of a qualified dentist.

Through the use of appropriate combinations of auxiliaries, well trained to perform limited expanded duties, more dental service can be rendered in an efficient manner.

Certainly at a time of rapidly expanding professional knowledge with increasing specialization there is an increasing need for team work.

"Dental auxiliaries who participate in the provision of dental care, primarily for school children, through government-sponsored programs have been established in several countries."⁸

The supervising dentist would in all instances be responsible for examination, diagnosis, treatment planning and treatment prescription.

Hygienists in a Public Health Program

In dental public health activity the dental hygienist could render a more effective and worthwhile service in many more areas than is possible at present. One of the most frustrating experiences of hygienists in public health activity is the practical impossibility of conducting an efficient examination, referral and follow-up programs.

It is a good idea to perform routine dental examinations for all school children; however, this aspect of a program is not successful unless something can be done to care for the defects found. If no effective action can be taken why go through all the expense and effort?

When manpower resources are lacking it would appear illogical to inform people

of their needs, and motivate them to regular care. This is not solving a problem. It could actually be creating problems because one could be augmenting the want when no money is available to pay for service, and for people who pay, one is augmenting the demand without having done anything concerning supply of dentists to satisfy the demand created. Though concern about dental health is good in principle any effective plan must provide needed care or at least make certain such care is available.

Prevention and education is of paramount importance to reduce the level of treatment needed and should precede treatment, but the treatment aspect must be associated if a complete job is to be done. Otherwise one is continually confronted with the frustrating process of determining what is wrong and being able to do anything about it.

This is by no means an undermining of the value of prevention.

The reduction of dental disease depends heavily on individual efforts. It is essential that one appreciates the value of good oral health and the effectiveness of preventive measures.

This can only be accomplished through an effective educational program. However, dental health education, while so necessary to dispel the widespread public apathy, fails to be truly effective unless patients are able to receive dental care along with the benefits of preventive services.

Early and regular dental care is one of dentistry's most effective preventive measures.

Several experiments have demonstrated that adequately trained dental auxiliaries can perform additional important oral duties of high quality, with the result that several countries have developed programs to care for dental needs by enveloping the expanded function concept.

Additional experimental programs are in progress, while still others are planned, to evaluate the practicability of dental auxiliaries undertaking a greater part in the delivery of dental care.

Most of the experimental projects have trained dental assistants to perform additional functions; others have trained dental hygienists while still others have developed an entirely new type of auxiliary. In addition, to add additional variety, the dental procedures delegated in the various projects have varied considerably. The basic purpose of all programs, however, has been an attempt to increase the availability of dental health services.

There is no single, simple solution to this complex manpower problem; however, one general conclusion is obvious — older established patterns will have to change and new patterns of dental service delivery must evolve to meet the changing demands. There will be a need for more dental clinics in schools and hospitals. It will also be necessary to establish fixed regional and mobile clinics utilizing the team approach. More operating dental teams will certainly become the mode of dental practice.

The first obvious step to solve the manpower problem is to increase the number of practicing dentists. The likelihood of providing all the needed dental service by this method alone, however, is rather remote, since the present and projected training programs for increasing the number of dental graduates will not be sufficient to meet demands alone.

The increased use of non-operating auxiliaries such as chairside dental assistants and support assistants (receptionists, secretaries, roving assistants) can increase the availability of service further. This increase will be further stimulated by technological advances in operator technique, as well as by research findings in preventive treatments per se.

A third necessary step would be to delegate to adequately trained auxiliaries, more demanding, but time-consuming duties, which primarily demand digital

skills, but do not require the dentists' training, knowledge and competence. Surely the dental hygienist is the logical choice for this assignment.

Socio-economic and political factors will undoubtedly play a large part in changing future patterns of dental care delivery.

Many experiments have been performed, while others are presently in progress to explore the practicability of expanding the duties of dental auxiliaries.

In the beginning, most experiments explored the possibility of expanding the duties of the dental assistant. These projects have been very worthwhile.

It is gratifying to see that currently considerable attention is being given to the future activities of the dental hygienist as far as expanded duties are concerned. Certainly this discipline can play a more effective part in the provision of dental services.

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FROM WITHIN YOU

“...excellence is not something that can be produced or sold in the market place; it cannot be legislated by government, and it cannot be conferred upon you like a college degree. It can only come from within yourself, and — at its highest — it is painfully born out of a restless dissatisfaction with things past and sired by an insatiable hunger for the unattainable.”

R.M. Blough

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POSTER

The Education and Recruitment Committee of the C.D.H.A. is sponsoring a contest for a poster to be designed for the "Careers in Dental Hygiene" pamphlet. The contest is open to all members and all junior members of the C.D.H.A. Those interested may obtain a pamphlet from their provincial member:

Ms. June Coe,
5 Spencer Cres.,
Vancouver 14, B.C.

Miss Nancy Gray,
83 Lennox Ave.,
Winnipeg 8, Man.

Ms. J. McIntosh,
-10640-111th St.,
Edmonton, Alta.

Mrs. S. Pitchford,
310-1059 Don Mills Rd.,
Don Mills, Ontario.

Ms. M. Wailing,
Box 197,
Regina, Sask.

Mrs. S. Taylor,
2910 Oxford St.,
Halifax, Nova Scotia

There is a cash prize of \$25.00 for the best poster.
The deadline for the contest is July 15, 1971.

Posters are to: — convey an appropriate message for the display of the pamphlet,
— be 8" x 10" — 20" x 22" on 4-ply bristol board
— be mailed to: Miss A. Kalsey,
633 Lodge Ave.,
Winnipeg 12, Manitoba.

REPORT ENVISIONS EXPANDED DUTIES FOR SUPERVISED AUXILIARIES

Ottawa is "very much in favour of helping to train dental auxiliaries in co-operation with the provinces," the House of Commons was told in the wake of a government report that recommended a large expansion in the number of duties which all classes of dental auxiliaries may perform.

The report by the Ad Hoc Committee on Dental Auxiliaries, led by Ontario Chief Justice Dalton Wells, was tabled in Parliament February 22.

The 12 member committee, which was established on June 13, 1968, as a sequel to the Royal Commission on Health Services, was set up to study the possible use of such auxiliary personnel as dental assistants, hygienists and technicians in providing better dental care services for Canadians.

Most of the committee's recommendations proposed ways to improve the training and certification of such people. But its report went a step further and recommended that dental care in a form similar to medicare be offered to all Canadians "as soon as possible."

Assistants, hygienists — The report rejects the creation of new auxiliaries, calling instead for the expansion of the permissible duties of dental hygienists and assistants. Those of the chairside assistant should encompass many of the present routine technical tasks of the dental hygienist. Both groups would be trained accordingly.

New duties for dental assistants would include taking impressions for study casts; placing and removing rubber dam and matrix bands; placing temporary restorations; removing dentures; rubber cup prophylaxis; supervising or applying topical anticariogenic agents; and exposing and processing radiographs.

Dental hygienists with the requisite training would be allowed to apply rubber dam; place sedative dressings; take im-

pressions for study casts; repair denture place and remove matrix bands; place orthodontic bands; prepare cavities; place and finish temporary cement, amalgam, silicate or plastic restorations.

Technicians, technologists — Turning to dental technicians, the committee said their duties should be defined in provincial dental acts as including fabrication, reproduction and repair of fixed or removable prosthetic appliances, crowns or bridges, as prescribed by a dentist.

Duties of technicians who complete further accredited training should be expanded to include fabrication and fitting of complete dentures or orthodontic bands directly for the public. These technicians called dental technologists, would perform the additional duties on prescription and under supervision of a dentist.

Education, licensure — The report said that dental assistants should in the future be trained in secondary schools and post-secondary institutions. Dental hygiene education should also be transferred to post-secondary institutions, leaving present university programs to come degree courses to provide training and supervisory personnel for regular dental assistant and hygiene training programs.

Formal training of dental technicians and technologists should be centered in post-secondary institutions, and apprenticeship training should be phased out, the committee said. The report also suggests shorter upgrading programs, equivalent to one full-time academic year for present technicians who aspire to become technologists.

The committee condemned British Columbia and Alberta for allowing "persons with dubious qualifications and record of illegal practice" to become licensed as dental mechanics. It found no support for the claim that this step would reduce costs and increase prosthetic service in rural areas. The report said costs have actually climbed

use most mechanics practise in large s where they must contend with g overhead costs.

However, the committee believes that licensing of dental mechanics is prob- irreversible. To get around the prob- it would bring them under prod new legislation governing dental nicians and technologists. Present nicians who wish to become tech- gists would have to submit to ad- onal training and examination for nsure.

Council on Dental Auxiliaries — Crea- of a Canadian council on dental ilaries and 10 provincial councils is posed as a means of fostering uni- nity in certification and accreditation educational and training institutions. Canadian council would have rep- ntatives from its provincial counter- ts plus additional members named by Minister of National Health and Wel-

Provincial councils would be com- ed of 11 members — three dental auxili- s (one each from dental hygiene, dental hnician and technology, and dental as- ant boards envisaged under proposed v provincial dental auxiliary acts), ee dentists (appointed by the provin- l dental association, the provincial tal licensing board and the provin- l health department), three laymen ap- nted by the provincial health minister, member appointed by the provincial edu- ion minister, plus the Minister of alth.

Dental care — The committee urged vernments to implement a system of ntal care — similar to medicare — to en- e all Canadians have adequate treat- nt for their teeth.

It calls on governments to build to- rd this universal dental care system by rting with a national dental program children. This could be extended year year until it included all school chil- en. It would then be extended gradually include the entire population.

The report suggested that while the national children's program was in its years of expansion, parents should have the option of sending their eligible chil- dren to public dental service available under the program or to private prac- titioners.

The committee called on federal and provincial ministers of health to accept the responsibility for planning, financing and operating dental programs supported by public funds.

Team approach — The manpower problem expected under a public dental care program could be met by upgrading the status of dental auxiliaries and in- corporating them in a team approach to dentistry.

Fully-trained dentists would do only the work that they alone were qualified to perform. Other more routine technical tasks would be the responsibility of per- sonnel specifically trained for these tasks.

Federal and provincial governments should devise incentives for dentists to employ the team approach. Dentists should be encouraged to expand dental office space and employ additional dental auxiliaries either in private practice or public clinics, said the report.

Did you hear about the new daytime television series in which all the char- acters are hippies—it's a sort of no- soap opera.

Somehow it takes women as long to dress nowadays as it did when they wore clothes.

P.E.I. DENTAL MANPOWER STUDY PROGRESS REPORT — 1970

By R.G. Romcke, D.D.S., D.D.P.H., Director, Division of Dental Public Health, P.E.I.

In February 1969 the P.E.I. Department of Health was awarded a federal government Public Health Research Grant (Project #601-7-9) to carry out a study to determine whether dental hygienists, who insert and finish dental restorations in cavities prepared by a dentist, can increase the productivity of a dentist to an extent that will make them economically worthwhile in a private dental office.

Three dental hygienists were given a two and one-half month training program at the Faculty of Dentistry, Dalhousie University from June to August of 1969. The hygienists were trained to apply rubber dam, matrix retainers, cavity liners and all types of protective bases. They also learned to insert, carve, contour, finish and polish amalgam, silicate, plastic and composite resin dental restorations.

The two year study, which is now half complete, is taking place in six private dental offices and a special public health clinic for children. The public health clinic is being used to provide data which cannot be readily obtained in private dental offices. Here various combinations of dental hygienists and assistants are being evaluated through productivity records, work sampling and time studies.

In the private practice part of the study, six private practitioners kept detailed records of every item of treatment performed for six weeks before the hygienist arrived and for the period when the hygienist was present.

The private practice part of the study was further enlarged when three private dentists, who had participated in the study, decided to obtain hygienists of their own on a permanent basis. The

P.E.I. Department of Health recruited three hygienists and a two month course was provided by the Dalhousie Dental Faculty in June and July of 1970. The three hygienists are now working on a two year contract basis with the three dentists. The three dentists will continue to keep detailed records of all treatments performed for up to two years. Since each dentist is paying all costs the change in productivity observed will be most meaningful.

In the public health clinic the dentist worked for 60 days with one assistant and then 60 days with two assistants. Two operatories were used. Then a third operator and a dental hygienist were added. Preliminary results show a 22% increase in productivity when a second assistant was added. A further increase of 67% occurred when a third operator and the dental hygienist were added. However, this latter figure is based on only the first 39 days of a 60 day recording phase. If these results are maintained the total overall productivity increase will be 108%. Several additional combinations of personnel and equipment will be studied in the public health clinic. The next phase will utilize four operators with two dental hygienists and three assistants.

Specially trained dental hygienists worked in six private dental offices for periods of from two to three months. Every effort was made to obtain complete information but the results are influenced by many variables. Such things as hours of work, type of equipment, office layout, number of assistants and the adaptability and attitude of the dentist affected the results. There were marked differences in the initial productivity of the six dentists, and one hygienist was more productive than the other. In some cases an assistant was added along with the hygienist. However, these differences are not entirely understandable because if an auxiliary is to be of any value to the profession she must be effective under the wide range of conditions found in different private practices.

Evaluation in the private practices based on the Relative Value Unit System as outlined in the 1965 Transactions of the Canadian Dental Association. This system forms the basis of most provincial fee schedules. In general terms each reduced surface and each extraction has an average value of 1 R.V.U. A full denture is valued at 15 R.V.U.'S while an examination is 1.25. Under the varying conditions described above, productivity increases of 15 to 32 R.V.U.'S per day are obtained by five dentists. The average increase in productivity was 41% in spite of the far from ideal physical facilities available. In the offices where two or three assistants were utilized the productivity increases were 50% or greater. Offices with only one assistant the increases were only 30-40%. It should be noted that in most cases the offices with two or three assistants had more suitable physical facilities as well. A detailed cost-benefit analysis will be carried out during the next few months. However, preliminary analysis indicates that the dollar value of the benefits will be very close to the value of the costs involved.

From our limited experience to date it seems probable that the dental hygienist with limited duties in restorative dentistry is indeed a valuable auxiliary in a private dental office. The quality of the restorations produced by the six dental hygienists involved is excellent.

All dentists who have participated have stated that they liked the system of practice and that they enjoyed being able to spend more of their time on more challenging procedures. Three of these dentists backed their enthusiasm with positive action by obtaining hygienists on a full-time basis. This action required the payment of \$4,000 to \$8,000 for dental equipment.

Patient acceptance has been excellent. There have been no problems whatsoever in this respect with the approximately 1,000 adults and the 1,000 children treated by the hygienists.

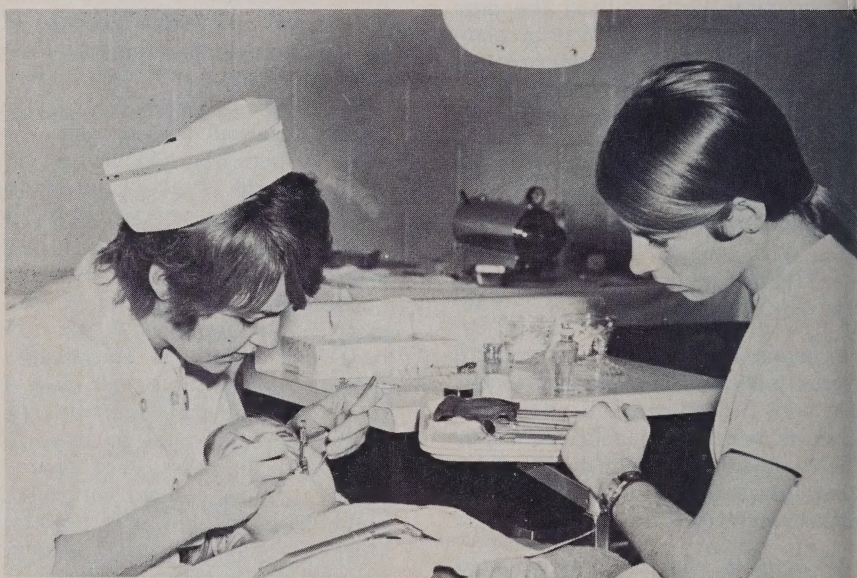
This concept of dental practice requires a three operator dental office. Varying numbers of dental assistants have been used but three assistants appear to be ideal. Best results are obtained when the three operatories are fully equipped. Here the dentist is followed from chair to chair by the dental hygienist. Patients are usually appointed three at a time.

The early results from the public health clinic indicate that this team approach has great potential value. However, until the study is complete the early results must be viewed with great caution. They are based on the work of one dentist and one dental hygienist in one specific treatment situation. However, preliminary stopwatch time studies indicate that the dentist and the dental hygienist involved possess almost equal speed. If both were 25% more or 25% less productive the observed percentage increase in productivity would be similar.

It appears probable that the addition of a second dental hygienist will make it possible for one team to provide complete dental care for up to 4,000 children on a continuing basis. Such teams could provide services in a four chair dental trailer with the staff commuting up to 50 miles. Children could be bussed in an additional 25 miles. Bussing becomes practical when a team can treat 20-25 children in a half day as is the case here. One such team could thus operate in an area with a diameter of 150 miles. This concept could well form the basis of a new delivery system for a dental care program for children.

The study project has created a great deal of interest throughout Canada and parts of the United States. Many requests have been received for reports on the project. The principal investigator described the project at the recent Canadian Dental Association Convention in Winnipeg and acted as moderator for a panel on the project at the recent Atlantic Provinces Dental Convention in Sydney, Nova Scotia.

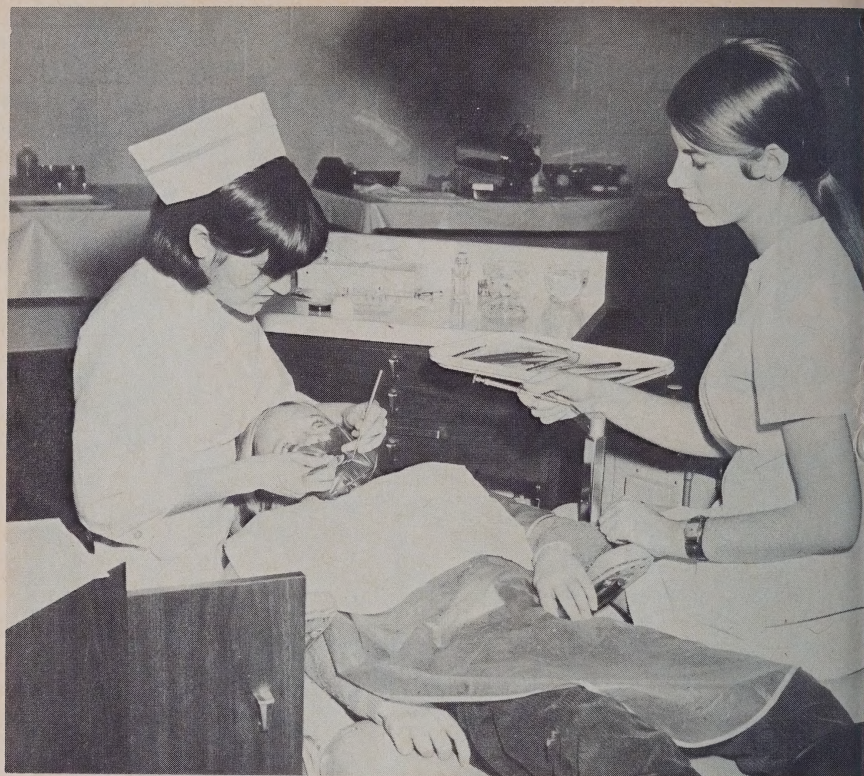
Dean McLean of Dalhousie University stated recently that the new duties, as performed by dental hygienists in this study, will be included in the regular dental hygiene curriculum at Dalhousie as soon as possible and hopefully this year. In preparation for these curriculum changes Dean McLean and members of the Dalhousie Dental Faculty have visited the various clinics and dental offices in P.E.I. where dental hygienists are being utilized.



Dental hygienist Mrs. Rosalyn Froehlick carves an amalgam restoration. Aiding her is dental assistant Arlene Corcoran.



view of a portion of the public health treatment clinic in the Prince Edward Island dental manpower study. Dental hygienist Mrs. Rosalyn Froehlick at chair 2 (right) is restoring teeth which were previously prepared by the dentist. She is aided by dental assistant Anne Corcoran. Doctor P.H. Creighan, aided by dental assistant Heather MacAulay, is preparing cavities at chair 1 (left). He will soon move to chair 3 (not shown). The dental hygienist follows the dentist from chair to chair. If she is delayed, Doctor Creighan completes the restorations himself.



Dental Hygienist Hazel McRae inserts a restoration made a few minutes earlier by Dr. Creighan. Assisting her is Anne Corcoran.

AL HYGIENE FOR OLESCENTS

sumarized from an article written by
rill G. Wheatcroft, D.D.S., F.A.C.D.,
essor and Chairman, Dept. of Path-
y, The University of Texas Dental
h at Houston, Texas, and by Sum-
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article first appeared in **Dental Clin-**
of North America — Vol. 13, No. 2
ril, 1969).

“Young persons should be urged to
p their teeth very clean, and the daily
of a toothbrush, with water only,
in most cases be quite sufficient.
In addition to the use of the brush, great
antages may be derived from the em-
yment of waxed dental floss. In this
the impurities that cannot be reached
the brush, are removed from between
teeth, and which, when permitted to
tain, cause their decay. If it were
sible to keep the teeth thoroughly
l constantly clean, they would never
ay.” (Fox, J., **The Natural History**
Diseases of the Human Teeth 1846,
73)

It is the purpose of this article to
cribe an effective method for teaching
escents and other dental patients
at they need to know about dental
blems in order to prevent and control
ies and periodontal disease. These
eases can be prevented when patients
derstand their nature and when they
motivated to practice an effective
l hygiene program directed toward
removal of the causes of their dental

neral Considerations

Dental caries and periodontal disease
velop in those areas on the teeth and
the gums where clumps of microbial
atter adhere and grow, on the tooth
aces and between those surfaces and
e gingival tissues. Members of the
ntal profession have had the effective
d necessary knowledge for a program
prevention of dental disease for many
eades. The reason people have dental
blems is because the simple facts are

not generally known and the patients are
not effectively motivated to use the knowl-
edge necessary to a practical program for
the preservation of their dental health.
It is the dentist's responsibility and ob-
ligation to help his patients to learn what
they need to know, but it is the patient's
responsibility to learn and to practice
these simple hygienic procedures that will
insure his dental health.

Soft Tissues, Secretions, Exfoliations

The mucous membranes of the mouth
secrete fluids which form a thin mucoidal
coating over the teeth, gums, tongue, and
inner cheeks which keep them moist
and slippery. This coating protects the
living cells and aids in the passage of
food through the mouth and throat. Sa-
liva, the specialized secretion from the
salivary glands, flows through the mouth
in a thin film down the throat and into
the stomach. The mucoidal secretions
from the mucous membranes and saliva
are nature's way to aid mouth cleansing,
deglutition, and digestion.

The epithelial cells which form the
outer layers of the mucous membranes
are shed constantly from the surfaces into
the mucoidal coatings and are carried by
the fluid flow from the mouth into the
throat. In addition, some white blood
cells work their way through the mem-
branes into the mouth. The shedding of
the covering cells and the ability of the
white blood cells to phagocytize injuri-
ous microbes explain why the gums,
cheeks, and tongue remain relatively
healthy in most people.

Sites for Microbial Growth

When the teeth erupt into the mouth
through the gums they furnish hard,
stable, nonreactive surfaces for the de-
velopment of “white deposits,” “bac-
terial plaques,” “microbial aggregates,”
or microcosms in sheltered areas on the
tooth surfaces. The hard, inert tooth sur-
face provides a favourable locale for the
colonization and growth of the communi-
ties of microorganisms. The clumps of
microbial matter are composed of sticky,
adherent bacteria, and many other kinds
of germs, protozoa, cells from our bodies,

and the mucoidal coatings constantly secreted by the gums and other mucous membranes. The living inhabitants of this microcosm thrive on tissue secretions, the cast-off cells, and one another. They are nourished and enveloped by the constant flow of viscous substances from the gums and mucous membranes. It is especially important that patients understand that these relatively invisible, hidden deposits on the protected areas of the teeth are actually tiny communities of millions of germs which can cause cavities and periodontal disease.

Mucoidal Coatings

The mucoidal coatings with their microbial residents stick tightly to the teeth, actually holding and sheltering the developing microbiotas. All substances do not readily penetrate the gels which form the matrix for the developing community of microscopic life. Hot or cold water will not remove them from the tooth surface. Mouthwashes have little effect on the microcosms or their inhabitants. Toothbrush bristles and dental floss when applied directly to the adherent masses dislodge them readily. When the microcosms are left undisturbed for a long period of time, portions of the masses on the tooth surfaces mineralize to form hard deposits called calculi. It is necessary to use special instruments in order to cleanse the mouth of these hard deposits.

Injurious Agents Produced by Microcosms

The living and the dying bacteria, cells, and mucoidal substances within the microcosms all release waste products as they go about their daily activity or degenerate into their essential elements. The nature of these waste products is dependent upon the kinds of foods or nutrients upon which the bacteria feed and upon the kinds of enzymes and other chemical substances released.

Dental Caries

Sugar is one substance which diffuses readily into the microcosms and can be converted into acid by many of the resident microbes or bacteria. When any food goes into solution in mouth

fluids and reaches the bacteria, digested to form waste products which combine with tooth minerals and tooth decays. Patients and dentists to use this knowledge to locate "trigger" food or food habit that associated with carious activity in mouths. Teeth do not decay unless able cariogenic foodstuffs are available to large numbers of bacteria living in the thick masses on tooth surfaces. The frequency with which foods are supplied throughout the day and night is an important factor.

Periodontal Disease

It is well known that mucous membranes permit the passage of many substances from the outside of the body to the inside. Food goes into solution and passes from the lumen of the intestine and goes through the mucous membrane to the neighbouring capillaries. It is essential to a successful program for prevention of periodontal disease for patients to know that the tiny, invisible microorganisms thriving in the hidden microcosms produce irritating substances which are absorbed or pass into adjacent gingival tissues. The gums absorb the irritants and waste products produced by the microcosms and an inflammatory response, gingivitis, occurs in the tissues. Gingivitis is pyorrhea. It begins when first teeth erupt and when white deposits form next to the gingival tissues. These microscopic changes are the first signs of periodontal disease. They cause little damage and enlarge so slowly that the first teeth are shed before the disease demands attention.

When other teeth erupt during adolescent years periodontal changes begin anew in those locations where adherent microbial masses have been undisturbed. There may be an acute flare up in an overlapping gum flap where microbial activity is particularly favored by the anatomic situation. Even the manifestation of the pathogenic potential of the oral microbiotas seldom serves to enlighten the patient regarding the true nature of periodontal disease or to stimu-

dentist to do other than excise the gingival flap or extract the erupting tooth. It is the dentist's responsibility to teach both young and old patients to learn about the ultimate destructive potential of microorganisms which are associated with plaque initiation and progression of periodontal disease. He is also obligated to help patients learn and to practice those hygienic methods which effectively remove these causative factors.

Diagnose the Disease

The first logical and correct procedure is to successful treatment of disease is to establish a diagnosis. Too many patients are treated for periodontal disease and dental caries without any attempt being made to find out what caused the disease. Carious lesions are restored without the dentist's determining why the lesions are present. When the dentist makes the diagnosis, whether for periodontal disease or for dental caries, he must inform the patient what caused the disease. Without this knowledge the patient will not understand the necessity for prevention of further problems. A patient has rampant dental caries which have been caused by poor food habits plus microbial masses on the teeth, and the dentist restores these teeth without correcting the patient's food habits and teaching proper cleaning procedures, has only partially treated the patient and has wasted much of his time and the patient's time and money since the cause of the problem has not been corrected and the disease will persist.

In addition to the usual diagnostic methods, x-rays, careful examination, and patient history, inexpensive phase microscopes are being used by many dentists. Samples of bacteria are removed from a tooth surface or a gingival crevice and are placed on a glass slide with a cover glass. The phase microscope enables the microbes to be viewed in the living state. When a patient sees these interesting and exciting forms and realizes they have been removed from his own mouth, he understands, probably for the first time, the cause of the disease and the reasons for home care procedures.

Demonstrate the Site

Disclosing solutions are used to demonstrate the masses of organisms which attach themselves to the tooth surfaces. The patient must understand that these masses are composed largely of microorganisms and that it is in these areas that cavities will develop if the microbes are left undisturbed. When the patients are learning how to clean the teeth they are reminded several times that the disease is caused by bacteria. This appears to be a motivating factor which can be reinforced by removing microcosms from tooth surfaces or gingival crevices and demonstrating the microorganisms to the patient. Since they are seeing microorganisms which came from their own mouths the personal relationship to the disease process has more meaning.

Help the Patient Learn to Remove the Cause

Patient acceptance of a program of disease prevention is dependent upon the attitude of the dentist toward the program. His enthusiasm for teaching is transmitted to the patient. This is especially true for adolescents in whom receptiveness for learning is still present. The dentist needs to use all the methods available to teach the cause of the disease and to help patients to learn to remove the cause. These methods must necessarily be tailored to the individual patient and the dentist.

At the University of Texas Dental Branch at Houston, each patient receives a dental kit (Available from Professional Relations Division, Procter and Gamble Co., 6000 Center Hill Rd., Cincinnati, Ohio, 4524) and a booklet which explains what he needs to know and to do to prevent dental disease. Just handing out the pamphlet is not sufficient; at a later appointment questions should be asked about its contents to see if the patient has been interested enough to have read it. Tell him to read it and that at a later appointment you will discuss its contents to determine whether there are parts he does not understand.

The "tools" we want our patients to use for home care procedures are provided for them. These include soft, rounded, bristle brushes and unwaxed nylon dental floss. Other adjuncts are recommended for special cases; for example, needles to clean under and around pontics and bridge abutments, and polished round toothpicks or similar aids to be used in some periodontal cases. Inexpensive mouth mirrors made of plastic help patients to see difficult-to-reach areas.

Pamphlets describing the use of floss, brush, and water sprays are used by some; however, the actual demonstration of techniques to the patient is probably more successful.

Use of equipment and techniques may at first sound complicated and time-consuming, but this is not the case. Little time is required on the part of the patient to control disease once the proper procedures are learned and incorporated into his daily routine.

Recall of Patients

Success in the continued prevention of dental disease depends on the partnership that is established between dentist and patient. Frequent recall is necessary to maintain the enthusiasm of the patient and the dentist, to point out areas that may have been missed, and to reinstruct when necessary. We have found that many of the patient's cleaning problems can be discovered and corrected if the dentist watches the patient brush his teeth and use floss on them.

It is difficult to establish a definite time for recall, for each case needs to be considered separately. It is an unusual patient who can go six months between visits. In our experience three months is an average time for better patients, and adolescents should be seen more frequently.

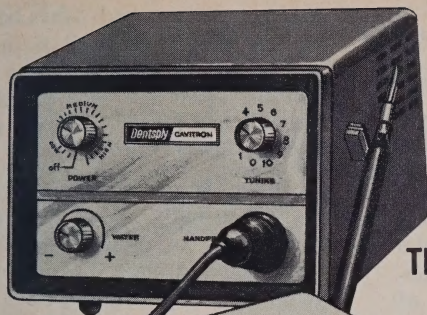
Treatment

The patient should be well instructed and should have demonstrated that his disease is controlled before restorative or periodontal treatment started. There will be clinical signs other than the absence of microbial masses on the teeth that the disease has been arrested. Early carious lesions, white spots will often remineralize. The carious lesions will become darker and the remaining carious dentin will appear hard when the microbes are removed daily by effective cleaning procedures. Gingival bleeding will disappear in a few days when the patient properly cleanses the crevicular spaces.

When these signs of disease control are present and when the patient continues to demonstrate at recall examination that he is cleaning well, the dentist can feel confident that he is helping patients prevent dental disease.

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away the whole family's on a



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TAKING IMPRESSIONS FOR YOUNG CHILDREN WHO GAG

Summarized from "Impressions for the Child who Gags," Hill, Gellin, J.A.D.A., Vol. 81, July 1970. Submitted by Mrs. Sharon Heise.

It is sometimes quite a difficult task to take an impression for a child who gags. It is necessary to identify a potential gagger and devise methods of distracting him. All equipment and materials should be prepared before the appointment as delay will increase anxiety. Proper choice of words is essential to assure an efficient technique.

Check with the parents; they may be able to help you decide if the child will be a gagger. Ask if he can swallow a pill without gagging, or is able to brush his teeth without difficulty. You can tell while working on the patient; check to see if he gags when the mirror or prophylaxis cup is being used or when x-rays are being taken.

It is best to make the appointments early in the morning with the child having had nothing to eat or drink. All materials should be ready.

It is suggested that the trays be rimless. If properly beaded with periphery wax, the impression material will not flow onto the tongue and initiate the gag reflex. The wax acts as a rimlock and may be prepared ahead of time. Use a fast setting alginate; further reduce the setting time by adding warm water to the alginate powder. The flavour should be pleasant.

Seat the child immediately in the chair and have the back at approximately 60° so both maxillary and mandibular impressions may be taken from the same position. Stand to the side and slightly behind the patient's head. The left arm encircles the head giving the child a sense of security. Take sufficient time to tell the child exactly what is going to be done. The bite registration should be taken

first as it gives the child a good introduction to the procedure. Have him include properly several times before inserting the wafer. When it is inserted you are ready to register the bite, let him just close his teeth together, as a command to bite may result in his biting very hard.

Take the mandibular impression as it is usually easier to obtain. Present the tray as a spoon or a dish and have the child place it in his own mouth. While it is in position have him breathe through his nose; this distracts him and also prevents him from swallowing. Have the tongue pressed against the maxillary incisors. Other traction devices are to have him wiggle a foot or a finger. Mix the alginate referring to it as pudding, mashed potatoes, or ice cream, and allow the child to smell it. For the extreme gagger insert the tray 5-10 seconds before the expected set time and remove it 10 seconds after this time. Smooth the alginate with a wet finger and do not have the tray filled higher than the periphery wax border. Insert the tray behind the posterior teeth and then bring it forward to the anterior. If gagging occurs bring the head forward.

For the maxillary impression the position of the tray is very important. It should not extend onto the soft palate. When filling the tray with alginate, have the material sloping from the anterior to the postdam area. Insert the tray at the posterior and bring it forward to the anterior. To allow the alginate to flow into the vestibule, flex the lip with the finger. A quick downward motion will remove the tray.

The child should be complimented and assured that at all times he will be told exactly what will happen. Tell him that he was a good helper.

GENETIC ASPECTS OF DENTINOGENESIS IMPERFECTA

rs. Barbara Baxter

Before dealing directly with the re of dentinogenesis imperfecta, a w of the way in which genes are ited may be helpful to the reader. umans the genetic material (DNA) ntained in 46 chromosomes consist- of 23 pairs. Twenty-two pairs are hing, or homologous, and are known otosomes. The 23rd pair is homologous males and these are referred to as X or sex chromosomes. In males this pair is non-homologous, consisting a X and a Y. The Y has been found e the male determiner. (Ford and bs, 1959).

All somatic cells are diploid, con- ing all 46 chromosomes, but germ cells aploid, containing 23 single chromo- s. Ova are all X bearing, but sperm of two kinds, either X bearing or Y ing. When fertilization occurs the two of 23 match up and "find" each r, pairing together during cell di- on. In this way the fertilized ovum ives half its chromosomes from its her and half from its father. If the n is fertilized by an X bearing sperm, individual will be female. If the m is Y bearing, the individual will ale. Let us over-simplify and suppose a single gene is responsible for den- genesis imperfecta and that it is lo- d on an autosome, that is, it is not linked, in which case it would be ted on the X chromosomes. (The Y s few known genes.) Because it is sex-linked the trait should be found ally among males and females in the ulation. If a defect follows a dom- nt pattern, an individual who pos- es one defective gene and one normal e will still show the trait, which he he must have received from one parent.

If we use **D** to represent the dom- nt defective gene, and **d** to represent normal allele (that is, its equivalent the other homologous chromosome

at the same locus or position) we can show its pattern of transmission. Let us suppose that the mother is **Dd**, since she has one defective gene, and the father is **dd**, since he is normal. She will produce two types of ova, half containing **D**, and half containing **d**. He will produce only one kind of sperm containing **d**. A Punnett Square is used to predict all possible offspring.

		Sperm	
		d	d
Ova	D	Dd	Dd
	d	d	dd

Looking at the square it is evident that half the offspring are **Dd**, and will have the defective trait, and the other half are **dd** and are normal. Dentinogenesis imperfecta is called a rare dominant because it is an unusual condition (1:8000) believed to have arisen as a chance mutation and then passed down within family groups carrying the gene.

Structural proteins usually follow this pattern, while enzymatic proteins follow a recessive pattern. This means that if an individual has one defective gene and one normal gene, he will appear normal. He must possess both defective genes for the abnormality to show. Albinism, for instance, is a recessive trait caused by an enzyme block in the conversion of tyrosine to melanin (which forms pigment). If **A** is the normal gene, and **a** the allele for albinism, the albino must be homozygous, that is, possessing both recessive genes, **aa**. The presence of one **A** will mask the condition, and the **Aa** will appear as normal. A Punnett Square shows the recessive pattern.

		Sperm	
		A	a
Ova	A	AA	Aa
	a	Aa	aa

In order for a person to be albino, both his parents must have carried at least one defective gene. If neither parent was albino they must have been both heterozygous, **Aa**. From the square it can be seen that of four possible matings, one will be **aa** and completely normal, two will be **Aa**, or heterozygous, and will be homozygous recessive, **aa**, and will be albino. Of the four, three will appear normal, that is they will be phenotypically normal but of different genotype.

In theory, a recessive trait is considered more harmful to the total population than a dominant trait, because carriers who appear normal and are difficult to identify, contribute defective genes to the total gene pool.

The homozygous rare dominant condition for dentinogenesis imperfecta has not been found. Theoretically, the chance of a mating between two persons with dentinogenesis imperfecta is extremely unlikely; however, Witkop has recorded one such case which is discussed later. Also, it is believed that two defective dominant genes would so disrupt the normal development of the embryo as to be incompatible with life.

It should be stated that the foregoing is an over-simplification, since many genes are usually involved in the expression of a trait, and there are relatively few clear-cut cases of single gene inheritance. For example, at least 12 different blood-group systems, each determined by a different and separate locus, have been identified. Furthermore, at most of these loci, multiple alleles are now known which exhibit co-dominance. Also, environmental factors play a very important role in development. Dental caries is a condition in which genetic factors and the environmental factors act together in the phenotypic expression of the trait. To assess the relative importance of each becomes an extremely difficult task for the geneticist. For the moment, however, we are dealing with a case of single gene inheritance in discussing dentinogenesis imperfecta.

DESCRIPTION

Clinically, the crowns of the appear peculiarly blue-gray or brown colour, with an opalescence or translucent sheen. The enamel sheers off readily and in many cases there is severe destruction of the crowns, which are worn down to the gums. Radiographs show the roots to be reduced in length, foreshortened, and the pulp chambers are occluded. Histologically, the enamel rods appear normal, but the dentin tubules are irregular in shape and distribution, with fewer odontoblasts. The dentino-enamel junction shows a lack of normal scalloping, which may account for the friability of the enamel.¹

Ivancie² proposed the theory that since the enamel layer of dentin is normal, the genetic defect is connected with a reduced viability of the odontoblasts. They degenerate early and become incorporated into the dentin matrix at the same time, there is some regeneration of undifferentiated mesenchymal cells in the pulp, which is incomplete. This continued process of degeneration and replacement of odontoblasts results in a limited production of dentin and final obliteration of the pulp cavity, giving the dentin an appearance of a Haversian system of bone.³

Chemical analysis of the dentin reveals a higher water and organic content than normal. Microhardness is compared to 125 for normal dentin.

Biochemical studies show a plasma phosphatase level of blood 2 to 5 times greater than normal, while dentinal alkaline activity is decreased to about the normal level.⁵

INHERITANCE

It has been established by Hogg, Finn, and Witkop that the dystrophy is inherited as an autosomal dominant trait since the condition does not show up in children unless visibly possessed by one of the parents. It is apparently due to a single gene difference from the normal.

dition, and if this is true, a theoretical 1:1 ratio of affected to normal would be expected if the trait occurs in a homozygous state. In a study⁶ of 220 parents and their 740 children, 357 children were found to be normal and 383 inherited the condition from one parent. In another family pedigree study, the ratio was 25 normal to 27 defective. The expected 1:1 ratio is maintained within chance variation. Witkop has found it to be 55.1% affected to 44.9% normal. The reason for this bias was difficult to ascertain, but it is believed due to increased fertility (i.e. more offspring) among affected males. The pattern of inheritance is in keeping with current theory that genes involving structural proteins follow a dominant pattern while genes controlling enzyme synthesis act recessively.

ANDYWINE ISOLATE

During the years 1955-1963, a remarkable study was undertaken of a racial (Caucasian, Negro, Amerindian) isolate occupying two counties in Maryland and part of the District of Columbia.⁷ Breeding prevailed among seven lines established prior to 1850, with eight new lines appearing after 1850, that is, only seven surnames occur in the isolate. Because of their unusual racial mixture, members of the clan were socially ostracized by both the Negro and white communities. In 1882, Aunt Sally Twyne, from one of the present day members descended, coined the term "we-sort-people" to distinguish group members from outsiders, or "you-sort-of-people." The term "We-sort" is still used today to describe clan members.

Extensive medical, dental, and sociological studies were undertaken of this group, because of the fact that a number of genetic defects were found there in much higher frequencies than occur in the general U.S. population. Of 2,809 people who received a dental examination, 164 were affected with dentinogenesis imperfecta, and of these, eight had "shell teeth," which Witkop holds is an "expression Variant."

In another interesting pedigree study regarding this particular defect, Witkop recorded that two half third cousins, both affected with dentinogenesis imperfecta, married. Of eight children conceived, two were affected, and the remaining six were aborted after an average gestation period of approximately 2½ months. Unfortunately, researchers were unable to obtain any of the fetuses for examination, but the evidence, though inconclusive in itself, gives credence to the current theory that for a rare dominant trait, the homozygous condition is probably lethal.

RELATED CONDITIONS

Two other conditions are usually mentioned in association with dentinogenesis imperfecta. Although their expression is phenotypically different, there is strong suspicion, though no direct evidence, that they may be genetically related.

Dentinal dysplasia is a condition in which the roots of the teeth have very little substance. Large areas of refraction about the apices cause drifting and early loss of teeth. The crowns appear normal, but the pulp chambers are occluded and the structure of the dentin shows severe disarrangement, though the odontoblasts are normal in number. The condition is transmitted as an autosomal dominant, and is much less prevalent than dentinogenesis imperfecta. Since transitional conditions between families with these defects have been studied, the possibility exists that they are different manifestations of the same genetic defect.⁸

Osteogenesis imperfecta (or o.i.) is a mesodermal syndrome characterized by brittle bones and deafness, though tendons, teeth and sclera are often involved. There are two main types, o.i. congenita, which is fatal at or shortly after birth, and o.i. tarda, which manifests itself later and is more compatible with life. The disease is inherited as an autosomal dominant trait, and because the teeth have the same clinical and histological properties as dentinogenesis imperfecta, some researchers believe the same gene

is involved, but that the degree of severity varies. However there is as yet no direct genetic evidence for this assumption. The bones of affected individuals show a reduced number of osteoblasts, and similarly their counterpart in dentin, the odontoblasts, are greatly reduced in number. The defect appears to be in the organic part of the dentin, resulting in a secondary decrease in mineralization.⁹ Biochemical studies reveal plasma phosphatase blood levels greater than normal, while alkaline phosphatase activity is greatly decreased, as is the case in patients with dentinogenesis imperfecta.

GENETICS IN THE FUTURE

The exact nature of the genetic defect at the molecular level remains unknown in spite of rapid advances in the field of genetics. There are a number of reasons why this is the case. First, structural proteins are composed of extremely large and complicated molecules. The defect may involve a small change in the molecule's internal structure which cannot yet be detected by biochemical means at our present level of technology.¹⁰

Secondly, no experimental animals with this defect are known to exist. Recently a severe human biochemical disease known as Hurler's syndrome, involving mucopolysaccharide storage has been found to have its counterpart in cattle. It is hoped that future study of these and other experimental animals will help to explain the genetic defect in humans as well.

Third, mapping of the human chromosomes has barely begun. Total human chromosome length is approximately 3,000 map units, bearing tens of thousands of genes.¹¹ Since experimental matings are impossible, and the generation time upwards of twenty years, the task is extremely difficult. However, progress is being made in this direction.

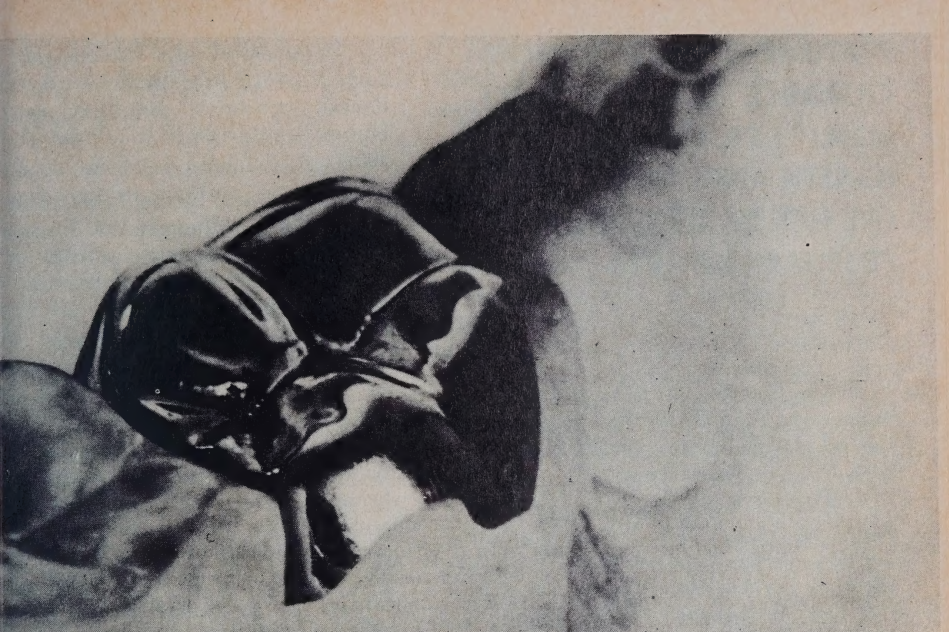
New discoveries are continually adding to our understanding of human genetics. While most structural human tissue is difficult to obtain for laboratory study, the tooth is an excellent source of

biological material and ideally suited for analysis. A defect such as dentinogenesis imperfecta may well be the one which provides us with the first direct chemical link between a genetic mutation and a defective structural tissue.

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*The control dentifrice was the Crest formula but without stannous fluoride and stannous pyrophosphate.
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†Evaluations by the ADA Council on Dental Therapeutics are limited to dental products made in the U.S.
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**STATEMENT BY THE HON-
OURABLE JOHN MUNRO,
MINISTER OF NATIONAL
HEALTH AND WELFARE, TO
THE HOUSE OF COMMONS,
FEBRUARY 22, 1971**

"Mr. Speaker, it is my pleasure to announce to the House that the report of the Ad Hoc Committee on Dental Auxiliaries has now been received.

"The Ad Hoc committee was established in June, 1968, by the previous minister of National Health and Welfare, the Honourable Allan MacEachen, with the full co-operation of the Canadian Dental Association. Its terms of reference were to study all aspects of dental auxiliaries, with special emphasis to the possible contribution that auxiliaries could make in helping achieve better dental health for the Canadian public. The Chairman of the committee was the Honourable Dalton C. Wells, Chief Justice of the High Court of Ontario, who is in the Speaker's Gallery.

"The report contains 43 recommendations. The first 21 cover such areas as the qualifications of dental assistants, hygienists and technicians, their training, education and experience, and a wide range of more responsible duties to enable them to contribute more effectively to the dental health care requirement.

"Other recommendations deal with the establishing of a Canadian Council on Dental Auxiliaries consisting of representatives from each of the provinces and others to be appointed by my department, to deal with matters of national certification and accreditation of educational and training institutions for dental auxiliaries, and the establishment by each province of a council on dental auxiliaries.

"The report also recommends that each province pass legislation regulating dental auxiliaries, and that provincial boards be established to administer the acts.

"A National Dental Program for children is also recommended. Such a program would incorporate prevention and treatment beginning with younger children and annually encompassing new age groups up to school leaving age.

"The committee also calls upon federal and provincial governments to provide incentives for dentists to develop a team approach to dentistry with support from dental auxiliaries, and for the governments to provide funds for training, research and facilities, and recommend that dental care in its broadest sense be offered to all Canadians incorporating the same principles of quality control and financing as medical care.

"Mr. Speaker, the recommendations contained in this Report will be studied most closely by my Department. Implementation of the report is of considerable consequence to the dental health of Canadians. Copies of this report are available for honourable members from my office."

TERLOO-WELLINGTON NTAL HYGIENISTS' CIETY

mitted by Mrs. Jane Rogers, Presi-

It took five years for the hygienists the Kitchener-Waterloo area to or- ze into a constituent society. The first mpt five years ago began when several he area hygienists, all graduates of University of Toronto, '65, decided it ld be of mutual benefit to meet oc- onally to compare notes about jobs working conditions. The first meet- was held at the Kitchener Y.W.C.A.

In September, 1970, Mrs. Elaine Good six of the hygienists at her home to a dinner meeting for October. This dinner meeting, attended by eighteen s, was a tremendous success. It was ded that with a group as large as , there should be an executive for con- nation and to organize informal meet-

The officers for this year are:

ident

Mrs. Jane Rogers (Hagen 6T5)

e-president

Mrs. Gail Ellis (Morkis 6T9)

retary

Mrs. Elaine Good (Adlington 6T6)

asurer

Miss Charleen Lee (7TO)

Many suggestions for community par- ticipation were brought forward at the : two meetings. To date, one of these been carried out. All the area high pools were contacted and were supplied n up-to-date information about dental iene. Members also volunteered to go, the high schools and talk to anyone rested in the course.

Mrs. Rogers comments, "we now es- lished and looking forward to the fu- . This is a growing area and we ect even more hygienists next year. nyone is coming to this area to live, p in and join us!"

ASSOCIATION OF PUBLIC HEALTH AUXILIARIES OF ONTARIO

A meeting, open to Public Health Hygienists and Assistants in Ontario, was held at Queen's Park in Toronto, on December 16th, 1970, to discuss the pro- posed formation of a Public Health As- sociation. Because the hygienist and as- sistant work together as a "Dental Hy- giene Team," it was felt that both auxil- iaries should be included in the same as- sociation. The limited opportunity for dental personnel in Public Health to meet to discuss new ideas or problems has prompted the proposal of this new group.

The purposes and objectives put forth for this association were the exchange of ideas in teaching methods, awareness of the varied duties and programs in dif- ferent areas, and to further interest in professional development, all to lead to a greater liaison among health units.

A majority was in favour of forming the association, elections were held, and the results were:

President: Mrs. Mary Lou Lunass

President-Elect: Mrs. Janet Baker

Secretary-Treasurer: Gina Shapka

Corresponding Secretary: Mary Bibby

Editor of Newsletter: Donna Calder

A membership fee of \$2.00 was set, the purpose being to cover the cost of the newsletter. The membership fee will be kept as minimal as operating costs will allow.

It will be necessary to have one communications representative from each health unit. This representative will be notified of meetings or workshops and it will be her duty to notify all members in her area of this event. Also, the dental director of each unit will select two members to attend the workshop and they will be responsible for reporting back to their area. For each workshop, it is hoped that different girls will be chosen to allow all members a chance to attend. At lease one business meeting will be held each year to which all mem- bers will be invited.

So far, two meetings have been held, business matters being conducted in the morning and the afternoons being devoted to professional development sessions. Guest speakers have included Dr. A. Green, D.D.S., who presented a "hypnosis in dentistry" demonstration, and Dr. E. Harvey of the Ontario Institute of Studies and Education. Dental education films have been previewed and discussed for use in the classroom. The Etobicoke Dental Unit has presented their summer program which involves "brush-ins" in the day camps and playgrounds of Etobicoke, a borough of Toronto.

It is anticipated that this new association will provide the forum for interaction and discussion that the dental hygiene teams in the province's health units now lack.

A Report on the Dental Auxiliary Services Committee of the Manitoba Dental Association—

—submitted by Mrs. Karen Hyman, member.

The Manitoba Dental Association Committee on Auxiliaries was formed in January, 1970 as a committee of the M.D.A. Board of Directors, with the following terms of reference:

"This committee shall investigate and bring forth definite recommendations pertaining to the maximum utilization of dental in-office ancillaries consistent with sound public health policies."

The following is a summary of recommendations:

- (1) A dentist licensed to practice in Manitoba, providing adequate supervision and assuming full responsibility, should be given more discretion in determining the functions a dental auxiliary can perform in his office provided that the auxiliary is formally trained to perform these functions.

- (2) The range of services provided by dental auxiliaries should be expanded enabling them to serve under appropriate dental supervision in any field of dentistry where they are required and which they are formally trained.

- (a) dental assistants should be permitted to work intra-orally under responsible supervision, performing duties for which they are trained.

- (b) consideration should be given to training the dental hygienists to provide restorative services to children in designated public health projects or in community health centres.

- (3) The career structure and education program for dental auxiliaries should be established so that the auxiliaries are promoted through progressive levels of skills and education along a single continuum for assistants and hygienists.

— Courses for training auxiliaries should be set up at community colleges and/or at comprehensive schools.

- (4) In view of the fact that it is recommended that dentists in Manitoba should be given more responsibility in determining the extent of utilization and supervision of dental auxiliaries in their employ, it is also recommended that there be imposed a form of quality control on services provided by dental auxiliaries.

There was a total of 21 recommendations made by the committee. Ten have been approved by the general membership of the Manitoba Dental Association, the Manitoba Dental Nurses' Association and the Manitoba Dental Hygienists' Association. The committee has been asked to meet again to further discuss and develop the recommendations of this report.

MESSAGE FROM THE MEMBERSHIP CHAIRMAN—

Jo Gardner

There seems to exist some confusion regarding membership. To help you understand I have explained some of the rules and policies below.

If you reside in a province having a Constituent Association, you can only be an ACTIVE member in that Association.

You may be an Associate member of your provincial Association IF you do not reside in that province. For example, if you reside in Ontario, you must be an ACTIVE ODHA/CDHA member, but you may also be an Associate member of the BCDHA.

You may be an Associate member of the CDHA if you reside in a province not having a Constituent Dental Hygiene Association (such as New Brunswick, Newfoundland), or if you reside out of the country. You may also be an Associate member of a Constituent Association such as Nova Scotia.

You may take out CDHA Associate membership either directly through the CDHA membership chairman or by paying both Associate CDHA and the provincial Association's Associate membership fees but be sure you don't pay the CDHA portion twice. When you receive the membership application forms indicate to the membership chairman that you have paid CDHA fees directly to the CDHA membership chairman.

5. If you move, please inform either the membership chairman of your provincial Association or the CDHA membership chairman, or both. If you do not, it is likely that you will not receive your Journal or other mailings. We have no way of knowing unless YOU inform us. This particularly applies to Junior Members who will be graduating this spring.
6. If you move from a province having a Constituent Association, you may apply for a transfer of constituent membership to the constituent Association to which you are moving, through your provincial membership chairman.
7. Same applies if you are an Associate member, but you would apply for transfer through the CDHA membership chairman.

To enable you to keep us informed of any moves, you may use the form below. Send it to your provincial membership chairman or to the CDHA membership chairman at the CDHA permanent address of 234 St. George St., Toronto, Ontario.

Date

NAME:

HOME ADDRESS:

WORK ADDRESS:

Member of the Association.

MISSING PERSONS

The membership chairman, Mrs. Jo Gardner, reports that the following members have not left any forwarding addresses. If you are on this list, or know whereabouts of any of these members, please send the new address to Mrs. Gardner. You may use the membership change of address form on page 39.

NAME	LAST KNOWN ADDRESS	SCHOOL AND YEAR OF GRADUATION
Miss Judy Barr	Toronto	Univ. of Toronto
Miss Joan Batchilder	Charlottetown, P.E.I.	
Miss Gladys Brassard	Alberta, thought to have moved to U.S.A. in 1968	Univ. of Alberta
Mrs. Mary Jane (Ballantyne) Eiv	Toronto	Univ. of Toronto
Mrs. Sharon (Graham) Hamilton	Vancouver	Univ. of Alberta
Miss Shirley Holmes	Campbell River, B.C.	Univ. of Oregon
Mrs. G.L. Jeffries	Alberta	Univ. of Toronto
Miss Pamela Johnson		Univ. of Toronto
Miss Janice MacLeod	Alberta—moved to U.S.A. in 1970?	Univ. of Alberta
Mrs. M.P. (Pelsen) McLoy	Toronto	U.S.A. School
Miss Elizabeth Maurick	White Rock, B.C.	Univ. of Toronto
Mrs. Dawn (Maywood) Mills	W. Vancouver	Univ. of Toronto
Mrs. Rose (Sutlin) Pettock	Ontario	Univ. of Toronto
Miss June Popescu	Ontario	Univ. of Toronto
Miss Donna Richards	Nova Scotia	Dalhousie '68
Miss June Schotz	registered in Ont. '68	Erie (U.S.A.) '68
Miss Heather Solway	Ontario	Univ. of Toronto
Mrs. J.A. Song	Ontario	unknown
Miss Paula Suokas	Ontario	Univ. of Toronto
Mrs. M.S. Swirsky	Ontario	Univ. of Toronto
Mrs. Sheril Tully	British Columbia	Univ. of Alberta
Mrs. Nina (Hughes) Wolff	Alberta ('67) may have moved to Seattle	Univ. of Toronto

U.S. IS CATCHING

On Saturday, March 20th, 1971, four hygienists of the interior of British Columbia met with Jo Gardner, Past-President of BCDHA and CDHA in Penticton. The meeting was for the purpose of forming a component society constitution and following this, the election of officers for the year.

The component society constitution prepared by ODHA was not helpful to the members in drawing up their draft. Following approval by the Board of Directors of the BCDHA, the Interior Dental Hygienists' Society will become the component of the BCDHA and the end within the structure of CDHA. Officers for this year are:

Miss Donna Gunther, President/Delaware, BCDHA Board
Mrs. Diane Hawk, Secretary / Treasurer.

The IDHS will meet at least once a year and likely twice, at the same time the Interior Dental Society meets. This will enable them to participate in IDS guest speaker programs. Following the organizational meeting, those attending went back to hear the afternoon session of Dr. C.W. Gardner's "Utilization of Dental Auxiliaries."

Organization on the 'local' level will help the hygienist in the outlying areas to have greater opportunity for participation in professional associations. Let us hope we can catch DHS fever.

INFORMATION REGARDING REQUIREMENTS FOR REGISTRATION AS A HYGIENIST IN B.C.

B.C. has been most fortunate in having a good many hygienists from other areas in Canada and the U.S.A. come to work as dental hygienists. However, there has been some problem in that the requirements for registration are not always known prior to their arrival. The following is what is necessary.

At the present time you are allowed to register without further examination, if you are a graduate of an approved school of dental hygiene in the U.S.A. or Canada.

- but** — you must provide proof of graduation, ie., a photostatic copy of your diploma.
- you must fill in an application form of the College of Dental Surgeons of B.C. (925 W. Georgia #325, Vancouver 1, B.C.)
- there is a registration fee of \$10.00 and an **annual** licence fee of \$15.00. (The above \$25.00 must accompany the application form.)
- if you are presently licenced, they would also like a photostatic copy of your current licence certificate or card.
- When you arrive in B.C., they would like you to come to the college office in Vancouver for further information on practice in the province of B.C.

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ANNUAL CONVENTION

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REGISTRATION RATES

	Pre-Reg. Sept. 15	Post-Reg.
C.D.H.A. Member	\$28.00	\$32.00
Non-Members	\$30.00	\$34.00
Junior Members	\$18.00	\$20.00

Pre-registration ends September 15/71 and refunds are available for pre-registration up to that date. Registration fees include attendance at all scientific sessions and luncheons. Tickets for the C.D.A. President's Ball (at \$20.00 per couple) and the evening at the National Arts Centre (ranging from \$3.50) will be available after registration.

Registration forms should be completed and sent to:

Mrs. Sylvia French,
306 Irene Cres., Apt. 5,
Ottawa, Ontario,
K1Z 7J1.

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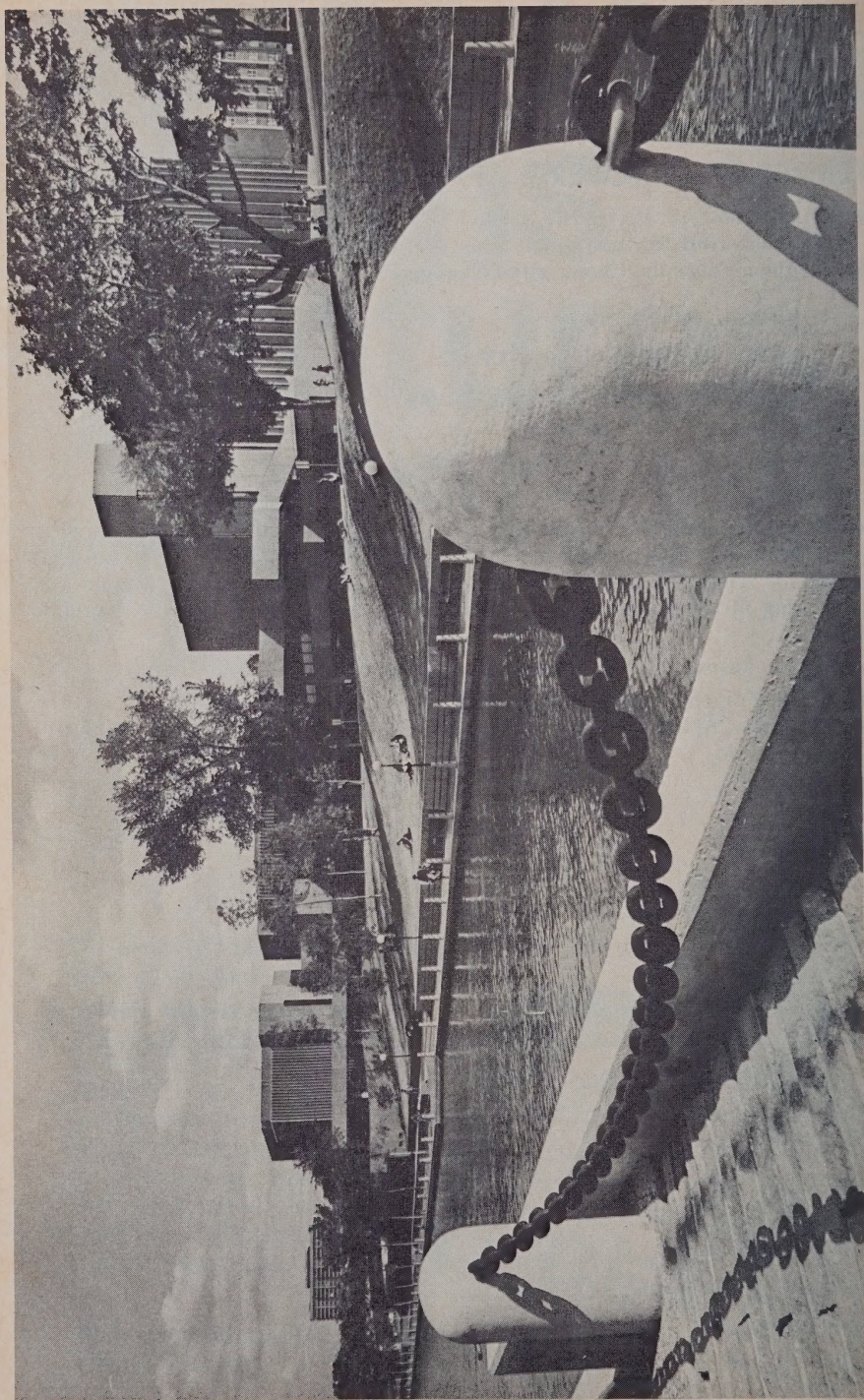
Will share with

Arrival date and time

Departure date and time

Name (please print)

Address



A view of the main entrance of the National Arts Centre as seen across a section of the picturesque Rideau Canal which flows through

1971 C.D.H.A. CONVENTION PROGRAM

Wednesday, September 29 to Saturday, October 2
Skyline Hotel, Ottawa, Ontario

Monday, September 27

- 00 Board of Directors' Meeting, first session
(if a third day of meetings deemed necessary by the board)

Tuesday, September 28

- 00 Board of Directors' Meeting, second session

Wednesday, September 29

- 00 Board of Directors' Meeting, third session
- 00 Registration begins
- Wine and Cheese Reception
- C.D.H.A. Hospitality Suite

Thursday, September 30

- 00 Registration
- 00 Orientation of the C.D.H.A. Advisors on Dental Hygiene Education
Leader: Mrs. Pat Johnson
- 15 Dr. T.M. Curry
"Dental Auxiliaries in Saskatchewan"
- 15 Findings of the Ad Hoc Committee on Dental Auxiliaries
Moderator: Dr. R.A. Connor
Panel: Dr. A.M. Hunt Dr. J.F. Reid
Dr. Marjorie Jackson
Dr. Bruce McFarlane
Mrs. Marnie Forgay
Miss Linda Twible
- 30 Luncheon
- 30 "The P.E.I. Dental Manpower Study"
Dr. R.G. Romke
"Preliminary Results and the Implications for the Future
of Dental Hygiene"
Mrs. Rosalyn Froehlick
"The Role of the Dental Hygienist in Operative Dentistry"
- 15 Miss Kate MacDonald
"Restorative Procedures for the Dental Hygienist"
- 30 Theatre Evening At the National Arts Centre

Friday, October 1

- 00 Seminar Discussion
C.D.H.A. Advisors on Dental Hygiene Education
- 5 "The Proposed Algonquin College Program in Dental Hygiene"
Panel:
Dr. E.J. Fox
Mr. M.A. Ryant
Mrs. Ruth Sword
- 0 Dr. G. Kravis
"Preventive Dentistry at Work"
- 0 Luncheon
- Eighth Annual Meeting of the C.D.H.A.

- 3:00 Informal Group Discussions on information presented in:
 – Ad Hoc Committee Panel Discussion
 – Algonquin College Panel Discussion
- 7:00 C.D.A. President's Buffet and Ball
 Chateau Laurier Hotel

Saturday, October 2

- 10:00 Dr. Helen K. Mussallem
 "Trends in Nursing Duties and Education"
- 11:15 Mr. George Cook, representing the Women's Bureau, Canada
 Department of Labour.
 Title Unannounced
- 12:30 Buffet Luncheon at the National Arts Centre
- 2:00 Table Clinics
 Chateau Laurier Hotel



T.M. Curry, B.D.S., D.D.S., D.D.P.
 F.I.C.D.

Dr. Curry graduated from the National University, Dublin in 1956. After a private practice in London, England, and a year in the School Dental Service, Oslo, Norway, he came to Canada where he completed his D.D.S. degree at the University of Toronto in 1961, and later returned there for post-graduate public health training which he completed in 1964. Since that time, he has been Public Dental Health Officer for Newfoundland, City Dental Health Officer for Calgary, Alberta. Dr. Curry is currently Director of Dental Health for the Province of Saskatchewan, and Assistant Clinical Professor of Dentistry at the University of Saskatchewan.



R.C. Romke, D.D.S., D.D.P.H.

Dr. Romke completed his dental degree at McGill University in 1954 and later returned to the University of Toronto for post-graduate training in dental public health, which he completed in 1967. Dr. Romke is currently director of Dental Health for the province of Prince Edward Island, and director of the P.E.I. Dental Manpower Study. He has served on the C.D.A. Dental Services Committee and is presently a member of the C.D.A. Council on Auxiliary Services Committee. Dr. Romke is also a past president of the P.E.I. Dental Association



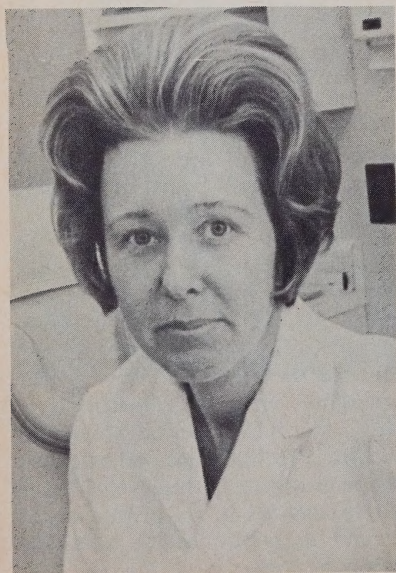
Rosalyn Froehlick R.D.H.

Mrs. Froehlick (nee Obrigewitsch) graduated from the School of Dental Hygiene, University of Manitoba, in 1968. After working for a year with the Department of Health, Dental Division in her home province, Saskatchewan, she attended Dalhousie University, Halifax, taking a special course in restorative procedures. For the past two years she has been working with the Department of Health on the P.E.I. Dental Manpower Study. Mrs. Froehlick has had extensive experience providing both preventive and restorative services in six private dental offices and in public health treatment clinics for children.



Kate MacDonald, R.D.H., B.S.

Miss MacDonald began her dental hygiene education at the Forsyth School for Dental Hygienists in Boston. From there she continued at Boston University and obtained her B.S. degree. Miss MacDonald has had a wide range of work experience in private practices and in public health before returning to the field of education, firstly as a dental hygiene instructor at Dalhousie University, later as an assistant professor at Old Dominion University in Norfolk, Virginia and currently as director of the Dalhousie University School of Dental Hygiene.



G. Kravis, D.D.S.

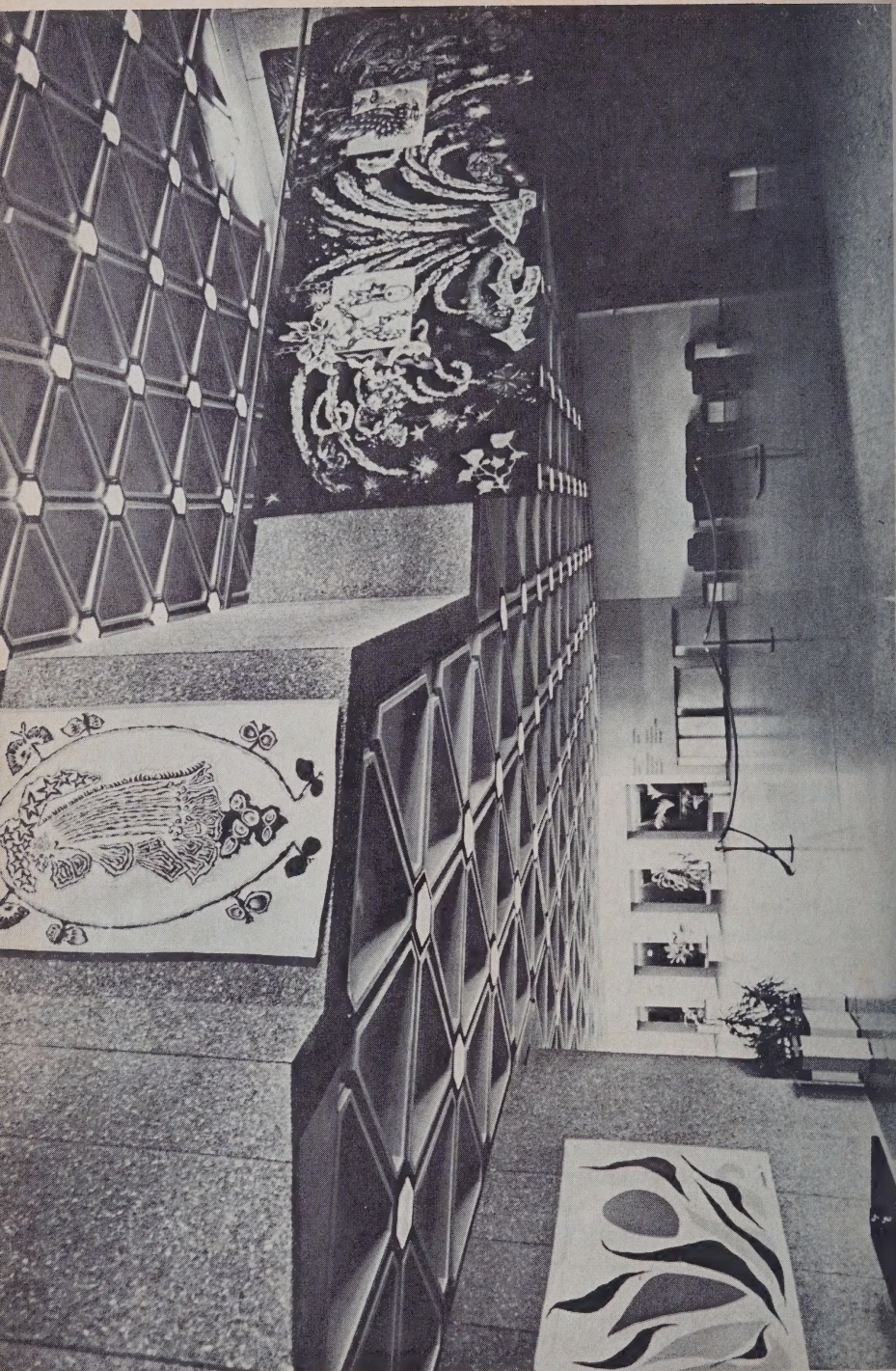
Dr. Kravis graduated from the University of Toronto in 1956. After several years of private practice in Toronto, she accepted her present position as Director of Dental Services for the Ottawa Board of Education. She happily combines her dental career with home-making as the wife of political cartoonist Ruskin Bond and mother of two children.



Dr. K. Mussallem, S.M., B.N., M.A.,
D., LL.D., D.Sc.

Dr. Mussallem began her nursing career after graduating from Vancouver General Hospital School of Nursing. She received her education at the University of Washington and McGill University where she completed her B.N. She returned to Columbia University, N.Y. for her M.A., and her Ed. D. Dr. Mussallem has had extensive teaching and administrative experience at Vancouver General Hospital. Since her affiliation with the Canadian Nursing Association, she has been a member of many boards,

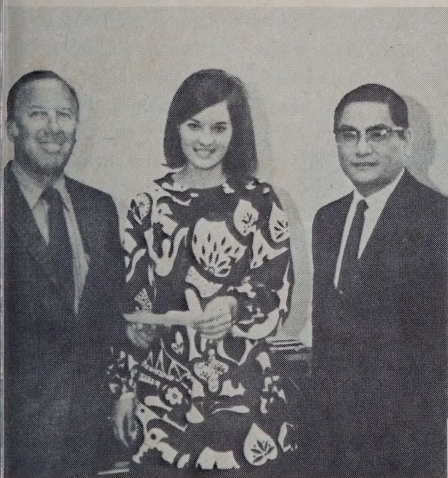
councils, and committees appointed to study health problems and their relation to the nursing profession. For her service she has been awarded the Order of St. John of Jerusalem, honorary degrees and awards from the University of New Brunswick, Memorial University, Newfoundland, Columbia University, N.Y., the Centennial Medal, and the Medal of Service, Order of Canada. Recently, Dr. Mussallem has joined two other women on the Economic Council of Canada as the first member of the health professions to receive this distinction.



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University of Toronto
no candidate until spring
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Miss Susan Inga Haglund
University of Alberta
Barbara Coyle and
Shauna Sullivan
University of British Columbia
Miss Evelyn Johnston.



Miss Evelyn Johnston of Vancouver receiving the C.F.D.E.
Scholarship in Dental Hygiene. Officiating are (left)
Mr. S. Margolese (C.F.D.E. Trustee) and Dr. S.W. Leung,
Dean, Faculty of Dentistry, University of British Co-
lumbia.

SOMETHING NEW IN DENTAL HYGIENE AT DALHOUSIE

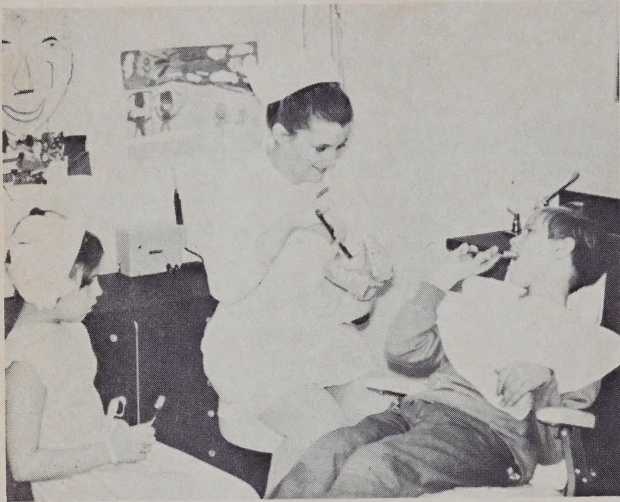
By Diane Charlton R.D.H.

In June of 1970 the Isaak Walton Killam Hospital for Children was opened in Halifax. Included in the design was a modern Dental Department staffed by a full time paedodontist and graduate dental hygienist. The department provides dental care for medically and physically handicapped children in the Maritime provinces. Children suffering from cardiac disease, mental retardation, metabolic disorders, blood dyscrasias and many other diseases are treated daily on both an In and Out patient basis.

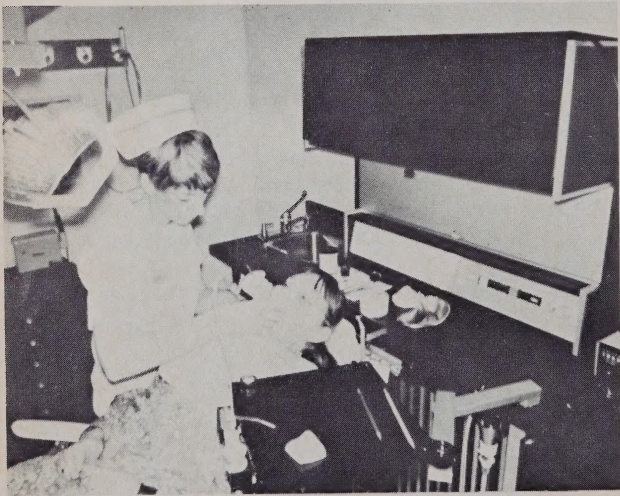
In September of 1970, second year Dental Hygiene students from Dalhousie University began two week rotations at the Dental Department of the hospital. Working in pairs, the girls visited individual patients on the wards, discussed dental health habits and gave tooth-brushing instruction. Time was also spent giving group instruction in the playrooms on each floor. Selected children were brought to the Dental Department from the wards for a prophylaxis and fluoride treatment.

There has been a very favourable response to this newly instigated program from both students and the hospital staff. The Dental Hygiene girls enjoyed the challenge of working with sick children and the nurses report that the patients have shown a new interest in their dental health.

**ISAAK WALTON KILLAM HOSPITAL
DENTAL DEPARTMENT**



Second year dental hygiene student giving tooth brushing instruction.



Diane Charlton giving prophylaxis and fluoride.

FLUORIDATION: STILL AN URGENT NEED

Best editorial reprinted from Parents' Magazine, November, 1970, by Luther Terry, M.D., Vice-President for Health Affairs, University of Pennsylvania.

When I was Surgeon General of the U.S. Public Health Service, I spoke often of fluoridation as a basic public health measure. I felt then, and do now, that all children should have as their birthright the full benefit of this health measure.

Yet still today, millions of American children suffer from tooth decay; dentists still fill and replace teeth that could have been saved by fluoridation. In too many areas of the country, an entire generation has grown up with an accumulation of dental ills that could have been prevented. I find these facts very disturbing — and so should every parent.

Twenty-five years have passed since the fluoridation of public water supplies began in this country. Experience over a quarter century reveals that fluoridated water prevents up to two-thirds of tooth decay that children would otherwise suffer. Furthermore, it is medically safe for people of all ages — and its benefits last a lifetime.

Fluoridation has paid off dramatically in dental bill savings. A study in Newburgh, New York, a city fluoridated since 1945, disclosed that five and six-year-old children from low-income families had only half the dental defects of their counterparts in the fluoride-deficient neighbouring city of Kingston. Newburgh children required half the dentists' time and less than half the money to treat. The same study underlines the special importance of fluoridation to disadvantaged children, who often lack the other elements of good dental health — adequate diet, good home care, and regular dental check-ups).

Fluoridation is now standard water-treatment practice in 7,500 communities throughout the United States.

In this ecology-conscious age, it's interesting to note that fluoridated water is a natural component of the environment in many parts of our country. Generations of our forefathers used naturally fluoridated water before the fluoride itself was discovered to be the reason for their good teeth. In research on the people living in these naturally fluoridated communities, both the effectiveness and the safety of fluoridation were proved. And so, even before fluorides were first added to water systems 25 years ago, we were confident of the results. It seems ironic, then, that at a time of high public interest in the environment, many communities are passing up a perfectly natural health measure.

And why, if fluoridation is so effective, is it still lacking in half the water supplies of our country? The reason is simple: fluoridation depends upon political action for its beginning in a community. The political action may be a decision of the mayor or city council, a referendum, or a vote of the state legislature. The progress of no other public health measure — immunization against disease, pasteurization of milk, and so on — has had to depend upon the vote of citizens.

Public opinion polls show that most people favour fluoridation, but a number are uncertain of what it means, and too many others are apathetic about voting on a dental health issue. It's been easy for the uninformed and the apathetic to get alarmed by the claims of a small but noisy group that has resisted fluoridation over the years. Even today, fluoridation's political progress is slowed by emotional opposition.

I am truly concerned about what is in fact a matter of national shame: that about half the children who could benefit from fluoridation are denied it. As long as adults remain indecisive about the issue, children will grow up with an accumulation of dental problems to plague them throughout life. Yet the preventive benefits of fluoridation are available at little cost.

I urge you as parents to make every effort to gain fluoridation for your children if the community you live in does not yet have it. Demand that your city officials and your state legislators take action — now.

SYNOPSIS OF CONTINUING EDUCATION COURSE

In March, the senior Dental Hygiene students from U.B.C. participated in a continuing education course entitled "A Day at Madigan in Preventive Dentistry." It was a unique and motivating experience for all fifteen girls. The course was held in the Officers' Beach Club at Fort Lewis, an army base fifteen miles south of Tacoma, Washington, U.S.A. Dental Hygiene students from Yakima Community College, Shoreline Community College, University of Washington, Clark College and the University of Oregon also attended the one day program.

The feature speaker for the day was Dr. Maury Massler, Associate Dean, Post Graduate and Teacher Education, from the University of Illinois College of Dentistry. Dr. Massler is active in the field of pedodontics and caries research. His topic was "Preventive Cariology," and during his talk, made us aware that the concepts in dentistry are forever changing. Since 1958, research information has stressed prevention rather than repair of dental disease, and the following points were brought to our attention.

1. Dental caries are not just holes in the teeth, but are the result of an infection of a specific organism — cariogenic streptococci.
2. That caries is transmissible and has been proven to be so in both animal and human research.

3. That in order for the very specific caries causing organisms to exist and to cause dental caries, there must be sucrose in the diet.
4. That even if a person has cariogenic strep present in the saliva and has a diet high in foods containing sucrose, the caries can be broken, broken by plaque removal.
5. Only those specific organisms which can produce dextrans from sucrose can produce caries.

Dr. Massler feels that there is a need for a dental health officer. This could be the dental hygienist. She could be more than a "scaler and prophylaxis queen." The dental hygienist should know **how** to prevent dental disease, and should be able to **educate** and **motivate** the patient in this prevention. This should be the goal for the dental hygiene profession.

Dr. Massler continued with his list of total or comprehensive caries control and prevention program, emphasizing the following points:

1. Removal of all bacterial plaque from all enamel surfaces and occlusal lesions. He stresses that flossing with pumice is far too abrasive and that a non-abrasive paste with fluoride incorporated with it should be used.
2. Reducing the ingestion of highly cariogenic foods containing sucrose by substitution. He pointed up the necessity of tallying a 7 day itemized accounting of what a patient eats in that period of time. Evaluation of this diet and correction of it.
3. Follow the removal of plaque with an application of a topical fluoride.
4. Institute a program of effective home care to keep the cariogenic plaques from reforming once they have removed them. This program can be most effective with the proper use of disclosing tablets.

home and disclosing solutions in the office. He felt it was more effective to have the patient brush first in the office, then use the disclosing solution to show him the areas that he misses, rather than just showing him the overall red mouth when he comes in. It is the overlooked areas of plaque that present the problems, and the patient must be made aware of where they are and **how** he can remove the plaque from these areas and **why** he must do so.

5. Repair of all carious lesions in the mouth.

Dr. Massler's studies at the University of Illinois Pedodontics Department have shown that when the above program is following at the most optimum time, further dental disease can be reduced or eliminated. Optimum time for the elimination of cariogenic flora in children is just before the eruption of the permanent teeth. The optimum time for fluoride application in children is soon after the eruption of new teeth. In adults it should be done immediately after the completion of single or multiple restorations, or the insertion of appliances.

The afternoon speakers were Lt. Col. Frederick Carlson who talked about "Oral Health Evaluation," and Lt. Col. David Layman who spoke on "Military Community Oral Health." Both men showed how oral health education to large numbers has improved dental health. Dr. Carlson spoke about group toothbrushing instruction, where fifteen patients are instructed by one dental person. He also outlined detailed instructions on how to effectively conduct a brush-in to children and adults. Dr. Layman spoke about the school programs that he has instituted on base at Fort Lewis. In the above situations, three points are stressed:

1. What is oral health?
2. What is oral disease?
3. What is the **patient's** responsibility to prevent dental disease?

The "Day at Madigan in Prevention" was a stimulating one for all those who attended, and the participants from U.B.C. were most appreciative of the opportunity.

Dr. Massler's presentation was originally published in the J. Tennessee State Dental Association 48: 109, April 1968, and excerpts from it were printed in the N.Y. Journal of Dentistry: Vol. 39: 3: pp 80-82, March 1969 and New Jersey State Dental Society Journal, April 1969.

GUARDIANS OF THE SMILE

by Mariam Tigrane

"Pick up your brushes... Dip them into the water..."

Twenty toothbrushes poised aloft swoop down into twenty small water-filled cardboard cups.

"Now brush — one, two, three, four!"

For a group of small Norwegian boys and girls in the Godia school in Oslo, the clear young voice of Berte Bjornsen marks the beat of the exercise. The nine-year olds are well accustomed to the drill.

In her left hand Berte holds plastic models of two enormous jaws filled with perfect teeth; in her right, a massive toothbrush with which she demonstrates the toothbrushing procedures to the children. She is doing more than teaching the correct way to brush teeth, something the children already know well. The cardboard cups, into which their well-trained hands dip the brushes, contain a fluoride solution, and Berte is making sure that all of the children's teeth are well protected with fluoride against tooth decay. The brushing is done carefully, methodically, in a relaxed atmosphere. No one laughs or nudges his neighbour. This little community is convinced of the importance of the work they are doing.

At the start of each tooth-brushing lesson, Berte enters the classroom carrying two paper bags containing the materials for this preventive exercise. On each child's desk she places a paper napkin and two cardboard cups. In the smaller cup she pours the fluoride solution, the other is for the children to spit into when they are finished.

The "good" students have all brought their own brushes. There are only a few forgetful ones, two or three at the most, and for them Berte picks some new brushes out of her paper bags.

As she pours the fluoride liquid she questions the children: "Why do you brush your teeth?" "How many times a day?" "And how about candy, do you eat a lot of it?"

All the children proudly proclaim that they brush their teeth at least twice a day, but they do admit to a certain fondness for sweets. Berte repeats the maxims that are prominently displayed on posters throughout the school; the apple and the carrot are your tooth's best friends; brush and chew your food carefully; avoid sweets and cakes between meals; rinse your mouth after meals.

When Berte is satisfied that all the children's teeth have been thoroughly exposed to the fluoride solution, she closes the cups and napkins, thanks the teacher who has granted her this quarter of an hour and goes back to her office where a group of smaller children await her. They are too young, too easily distracted to derive much benefit from collective exercises. Instead, in small groups of five or six, Berte teaches them to apply the fluoride solution themselves. First they practise on a large plastic model, then they use their own small brushes in their mouths.

The task facing Berte and her colleagues is not confined to distributing the fluoride solution. She also teaches general dental hygiene and has many brightly coloured visual aids at her disposal to help on this task. Fierce lions, snarling tigers and cheerful squirrels all proudly display their superb teeth; they are standardbearers of dental hygiene in Oslo schools. Tand-Ola (Ola-with-beautiful-teeth) is the hero of comic strips where he is usually seen munching an apple or a carrot.

Parents also take part. The mothers of the youngest children are invited to come to school, where they follow first lessons together with their children. Parents' permission must be obtained before fluoride applications are given; refusals are rare.

Oral hygiene, prophylaxis and treatment occupies about half a dentist's working time, the rest being taken up with cleaning teeth and removing decay. Dental cavities, troubles in spacing of teeth and poor condition of the gums are referred to the school dentist. He also treats the children in

ool, though more complex forms of treatment are provided in a central clinic. At Tveita school, another dental hygienist, Ester Dahl, is at work cleaning and removing calculus from Frode's teeth while Susanna waits her turn. Mrs. Dahl explains each action to the boy, who can see what is going on in a mirror he holds in his hand, and she takes advantage of the opportunity to give some additional lessons in oral hygiene. Since Frode and Susanna are both adolescents, her most convincing argument is that healthy teeth are a smile attractive, for boys as well as girls. (The fact that Ester Dahl and Berte Bjornsen have beautiful teeth proves more convincing than any number of sermons. What is more, their enthusiasm and conviction are contagious.) Afterwards, Mrs. Dahl fills out her patient's card where all the dental care throughout the school years is regularly recorded by dentists as well as by hygienists.

Ester Dahl has been practising her profession for twenty years now; she began in Bergen before coming to Oslo after her marriage. She is responsible for five schools and cares for about eleven to twelve children a day, working from eight in the morning to three in the afternoon. She alternates cleaning sessions with lessons on brushing and dental health.

Berte Bjornsen has had the same education as Ester: a year at a school to earn a diploma as a dental assistant followed by a year of specialized instruction as a dental hygienist.

There are 19 dental hygienists in Oslo, each responsible for about 2,000 school children. About a dozen of their colleagues work in other Norwegian cities.

Dr. Olav Engh, head of Oslo's dental service, emphasizes that dental hygienists are indispensable for his service. His only regret is that there are so few of them. With a population of about 1.5 million, the Norwegian capital has 50,000 children between the ages of 5 and 15, all of whom are entitled to dental care as they require it. By the time

they are three years old, 70% of children already have caries. At age eleven, the proportion reaches 95%. By fourteen years of age, nearly all suffer from caries. In addition, many cases of malocclusion occur and Dr. Engh estimates that nearly 40% of school children need treatment for this defect. These figures are by no means exceptional and the same situation prevails in many countries.

Preventive measures to protect children's teeth are of primary importance for good dental health. In many cases the damage has already been done by seven years of age, which is why Oslo has begun to organize a dental program in kindergartens where children start at the age of four. Eleven thousand children already benefit from this service that will help protect their primary teeth, which are of vital importance to the health of the permanent teeth to come.

The total number of dental hygienists is nearly 20,000, currently practising in over twenty countries. The United States has 14,000, Japan more than 3,000. Both Canada and the United Kingdom have 400, Thailand about 900, and there are smaller numbers in another 16 countries. Dental hygiene attracts men as well as women, and this profession will certainly grow in the future as humanity faces its enormous dental needs. These vital "guardians of the smile" lighten the dentist's load and allow him to concentrate on those tasks for which he alone is qualified. The dental profession is gradually accepting the concept of providing preventive and early operative dental care for children to help control dental diseases.

If it is true that physicians are needed throughout the world, dentists are in even shorter supply. The increasing demands placed on the existing number of dentists to care for the growing needs of the ever increasing populations throughout the world can be greatly facilitated where dentists are helped by dental auxiliaries. The surgeon-dentist as head of the dental team, in private or

public practice, benefits as well as his patients by the competent assistance of auxiliaries. Thanks to them he can provide dental treatment to a larger number of people and render more services to the community.

DENTAL COSTS CUT

Toronto: — Fluoridated water has cut costs of dental care in half, a survey of 1,300 children in suburban North York has revealed. Dr. D.W. Lewis, a public health specialist with the University of Toronto faculty of dentistry, said a five-year study of children before fluoride was added to drinking water in 1963 showed the costs of dental treatment amounted to \$63.00 per child. The cost was reduced to \$34.00 per child after fluoride was introduced, he said.

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CAN WE HELP OUR COLLEAGUES?

During our years of practice, we will often come across a new method, or a shortcut to do our routine procedures. Why keep these to ourselves? Other hygienists could benefit from your ingenuity. This column will be a regular feature, so please submit your suggestions to the editor. Here are some that have been collected from various sources:

1. If using fluoride gel for topical application, and you have different colours, give the child a more positive attitude by giving him the choice of which colour you should use.
2. If using a saliva ejector tip, the mouth can be very effectively and quickly cleaned by having the patient close his lips carefully over the tip of it like a straw. Warn the patient if you have a very powerful vacuum.
3. A little dry pumice when added to the prophylaxis paste provides an easier method for removing stain.
4. Occasionally spray your room with a pleasant smelling room deodorizer. This will eliminate the antiseptic odour so many patients associate with a typical dental office. Fresh cut flowers will also give off a pleasant scent as well as brightening up the operatory.

IN CLOSING...A SMILE...

"Out of the mouth of babes... Don't some children innocently say the funniest things? Here are just a few that I have collected over the past year. You are invited to submit your funny collections. Let's all get a smile out of them.

I had just given my little patient a shiny ring at the end of the fluoride appointment and told him that he was a good boy. He noticed my diamond ring at this point and remarked, "I see you have one of these rings too."

My patient's mother entered the operatory after I had finished the appointment with her little girl and commented that I had quite a conversation with her daughter. It seems she overheard the girl tell me that her father didn't flush the toilet!

Instead of telling me that he brushed his teeth after meals, the little boy said that he brushed them before he ate. I said that his mother did that all the time. I noticed that his mother wore dentures!

"What's that?"

Hyg: "A Mirror."

"What's that?"

Hyg: "A light."

"What's that?"

Hyg: "A probe"

"What's that?"

Hyg: "You ask too many questions"

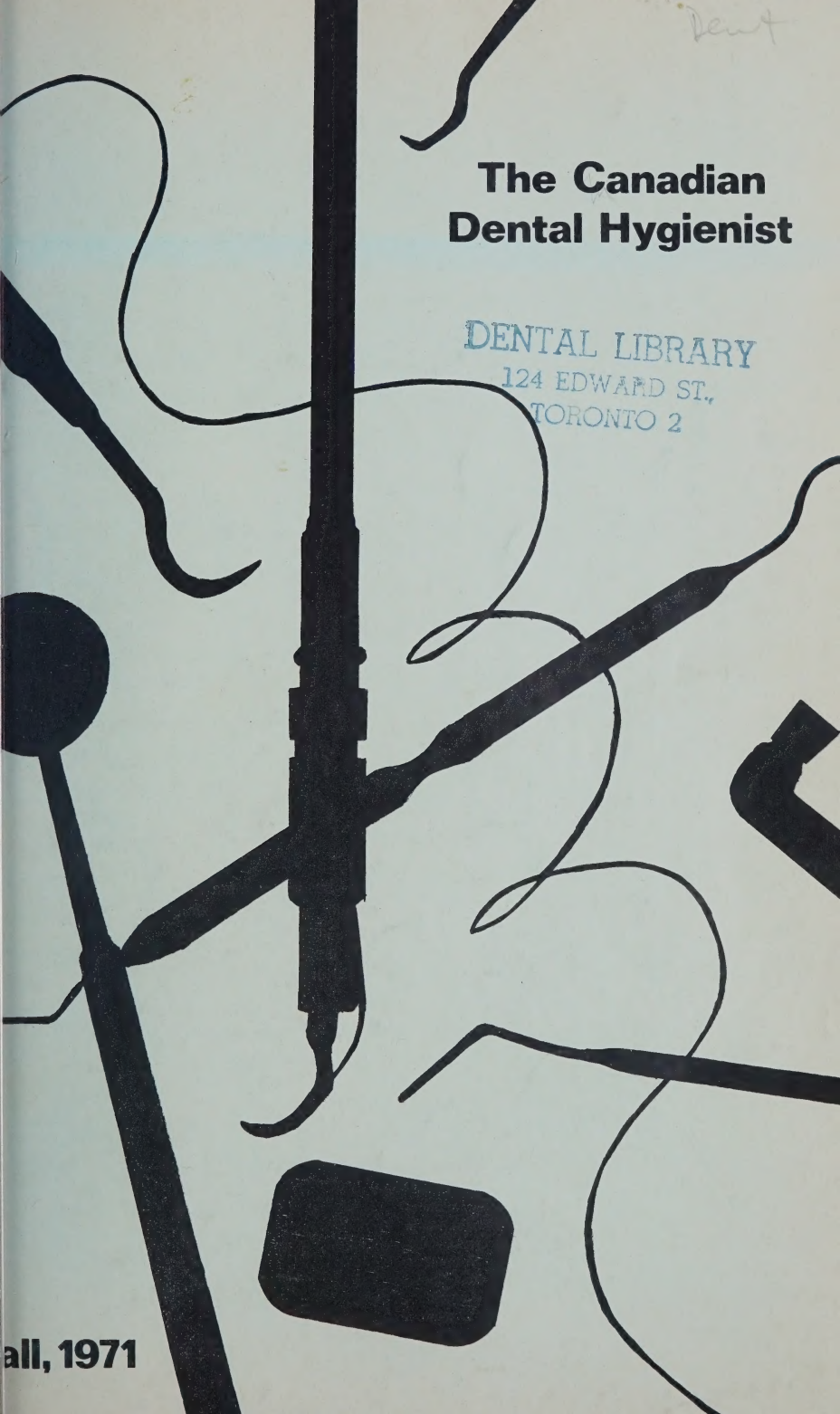
"I have four kittens!"

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The Canadian Dental Hygienist

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TABLE OF CONTENTS

Editorial	4
President's Message	5
A.D.H.A. Convention in Atlantic City	7
1972 Budget	8
Poster Contest	9
Results of the 1971 Meeting of C.D.H.A.	
Board of Directors	10
C.F.D.E. Month a Success	14
1971 Convention Report	16
Dental Auxiliaries in Saskatchewan	18
Presentation by Dr. G. Leatherman	19
The P.E.I. Dental Manpower Study	21
The Role of The Dental Hygienist in	
Operative Dentistry	21
Restorative Procedures for the Dental Hygienist	25
The Report of the Federal Government	
Ad Hoc Committee on Dental Auxiliaries	30
Panel Discussion on the Ad Hoc	
Committee Report on Dental Auxiliaries	32
C.D.H.A. Policy Statement and Endorsement	35
A Career Structure for Dental Hygienists	36
C.D.H.A. Pins and Charms	36
Preventive Dentistry at Work	37
Trends in Nursing Duties and Education	38
New Educational Slide Available	39
1972 Convention Reminder	42
Prevention: How Far Do You Go?	43
Message From The Membership Chairman	48
Mechanics Issue in Nova Scotia	50
New Books	51
In Closing—A Smile	52

INDEX TO ADVERTISERS

Block Drug Company (Canada) Ltd.	O.B.C.
Dentsply International	49
Procter and Gamble	3
Richardson Securities of Canada	15

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5. J. Dental Res., 39:871, 1960
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13. J.A.D.A., 73:853, 1966
14. J.A.D.A., 77:594, 1968
15. J. Canad. Dent. Assoc., 36:262, 1970

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EDITORIAL

How often have we sighed inwardly at the sight of teeth presented coated with tobacco stain? How many hours have we laboriously scaled and polished and lustrated, only to have it back, as heavy as ever, four to six months later? Do you find your patients trying to improve their oral hygiene? If not, try to analyze your presentation. Have you mentioned the effects of smoking on their oral tissue? the long term effects of smoking on their general health, or the effects of smoking on their physical appearance?

The December, 1970 issue of the Journal of the American Dental Association points out that "there is a well established link between the role of smoking and a variety of diseases including coronary artery disease, peripheral vascular disease, cancer of the lung, lower lip, larynx, esophagus, and oral cavity; chronic bronchitis, peptic ulcer and emphysema. The dentist (or dental hygienist), recognized by the public as being an expert in health matters, is in an excellent position to motivate patients to stop smoking. By pointing out the untoward effects of smoking on social acceptance by peers, its causative agent for hairy tongue, halitosis, altered sense of taste and smell, increased periodontal disease, discoloration of teeth, delayed wound healing, sinusitis, leukoplakia, and oral cancer, he can give the patient the needed incentive to attempt to break the tobacco habit."

We are the most qualified, we of the dental hygiene profession, to tell patients the latest medical views on smoking and oral disease. We spend a considerable amount of time and effort removing deposits to improve their appearance and protect their health, all for nothing if they continue to smoke.

Miss Jackie Samson, Editor



President's Message

Dear Members,

We have probably all at one time or another heard the phrase or possibly even used it, "you get out of something only what you put into it". This concept is very true and most certainly applies to Dental Hygiene.

In relation to other professions Dental Hygiene is a relatively young one, yet, I feel it affords one of the most dynamic and progressive opportunities of many professions in Canada today. Why? It is because of the people involved in Dental Hygiene. Only through the support of people as yourselves and the people you work for (the Dentist) could Dental Hygiene progress as quickly as it has and for this reason I am pleased and feel very privileged to represent you this year.

I don't think I have ever been as proud of Dental Hygiene as I was throughout the convention in Ottawa this past October. Because of the diligent efforts of Cathy Thom and her Ottawa Convention Committee the tone of change and progress was evident throughout the week.

The convention portrayed an image of our future and the theme "Dental Hygiene Faces the Challenge of Change" fitted aptly. During the week every hygienist present had the opportunity to learn where Dental Hygiene was heading in Canada and even voice her own opinion.

Indeed as was unanimously decided at the convention Dental Hygiene in Canada has "Accepted the Challenge of Change" and now it is up to every one of us to familiarize ourselves with the changes, consider their influence on us directly and the influence on the delivery of Dental Services.

Our numbers increase yearly and as is inevitable with Growth and Time, all around us changes and Dental Hygiene is no exception. If our progress is to continue we cannot remain static. People change, needs change but people will always need people.

Dental Hygienists are a certain kind of people with a specific education giving them the ability to perform a certain service for other people. Our education also presents us with a basis or foundation on which to increase our knowledge and therefore increase our service to the people. As a profession we must not define our operational limits according to our own interests but rather according to the needs of the people we serve and the ability we have to serve those needs. As a profession we have had the opportunity of a background education on which to expand our knowledge and we have a Responsibility to do so.

Of course prevention and education are the primary functions and interests of Dental Hygienists. Have we ever clearly defined in our own minds what prevention and education really are? To what avail is prevention without treatment or treatment without prevention? I would hope that you will consider them simultaneously as part of the same procedure and our ultimate aim, complete dental care involving the efforts of a Dental Team.

Where do we fit in this team? Possibly we could define a comprehensive list of duties according to an arbitrary standard, but I prefer to think that we will fit where we are needed depending on the area and the people we are working with. If it is necessary that we expand our duties as well as performing the traditional duties then we must prepare ourselves. I agree it would be ideal if we could perform our traditional duties only but dental care in Canada is less than ideal and what can we do about it?

You are probably all familiar with the "Well's Ad Hoc Committee on Dental Auxiliaries" and their report released in 1970. This committee for two years studied present dental auxiliaries in Canada and their utilization. The committee made many recommendations concerning Dental Hygiene and expanded duties.

The C.D.H.A. Board of Directors consisting of your representatives held a special session in Ottawa during the convention to consider the Ad Hoc report. We all agreed to support the recommendations in principle and do our part to implement them. It is now up to every Dental Hygienist to see that our endorsement is honoured.

I hope you will seriously consider your part in the future of Dental Hygiene and how expanded duties will effect you.

Keep in mind that we are only as useful as the need we serve and the need we serve should always be "Pro Bono Publico" and after all isn't that what it is all about?

Sincerely,
(Mrs.) Linda Zamboli
President

ATLANTIC CITY—

AMERICAN DENTAL HYGIENISTS' ASSOCIATION CONVENTION

A report by Mrs. Linda Zambolin, President, C.D.H.A.

What could be more welcome in a strange city only three weeks after being installed in the office which brought you there than friendly greetings that made you part of the whole situation? This was my good fortune when I arrived in Atlantic City for the A.D.H.A. National Convention, where I had the honour to represent the C.D.H.A. and bring our greetings to their general assembly.

During my two days at the A.D.H.A. Convention, where I had an opportunity to hear Diane McCain, A.D.H.A.'s incoming president, summarize her aims and those of her executive for the coming year.

Identifying and meeting the oral health needs of the public have top priority on the list. Mrs. McCain feels that this aim depends upon "three R's"—Recruitment, Retraining, and Retention. More dental hygienists must be recruited from rural areas. Hygienists must be trained for expanded duties. "Professional people should be a flexible means of achieving expanded training", states Mrs. McCain. Continuing education programs were suggested as a means of retraining hygienists in the work force and "recalling" after a period of absence.

I was welcome at all meetings and was able to be present at District Caucus meetings where delegates from all districts got together with members of their district to discuss matters before they were voted on at the session of the House of Delegates. I was present at Reference Committee meetings where specific matters to be voted on at the House of Delegates were presented for open discussion to the delegates and general membership. Then back to District Caucus meetings for the last chat before the voting. It was all extremely interesting and informative. Many matters being discussed were similar to matters our delegates had discussed only three weeks before in Ottawa, i.e. expanded duties, prerequisites for relicensure, continuing education programs, and new categories of membership: retired members or allied members (someone who has contributed to the profession and is interested in it but who is not a dental hygienist.)

During the scientific sessions several pilot projects dealing with expanded duties were discussed. One of particular interest involved training dental hygienists to perform minor gingivectomy and gingivoplasty. Others involved training in restorative procedures and the administration of local anesthetic.

It would seem almost inevitable. Changes are occurring everywhere. Many states have already adjusted their legislation to accommodate the expanding role of the dental hygienist and it is only a matter of time before many others will follow. And what about the C.D.H.A.? Well, I had an opportunity to let them know that the C.D.H.A. is not following, but is right alongside doing her part as well.

APPROVED BUDGET OF THE CDHA

ITEM	SPENT 1970-71	APPROVED 1971-72
1. Executive Council	\$ 375.02	\$ 500.00
2. Executive Travel	79.66	530.00
3. Board meeting		
(printing)	544.56	775.00
(a) Executive travel	92.00	1,290.00
(b) Delegates travel	474.00	300.00
COMMITTEES		
4. Membership	205.06	230.00
5. Editorial	740.66	1,000.00
6. Constitution	38.69	75.00
7. Convention '71	200.00	—
8. Convention '72	25.00	200.00
9. Convention '73	—	50.00
10. Nominating	—	10.00
11. Education and		
Recruitment	18.00	50.00
12. (a) Subcommittee on		
Education	10.09	25.00
(b) Workshop on Dental		
Hygiene Advisors	1,500.00	—
13. Manpower and Utilization	—	75.00
14. Scholarship	35.13	60.00
15. CFDE Donation	—	100.00
16. Public Relations	2.10	50.00
17. Community Dental Health	5.36	35.00
18. Ad Hoc Committee on		
Insurance	—	10.00
MISCELLANEOUS		
19. Stationery	325.02	200.00
20. Editor's Honorarium	100.00	50.00
21. Auditor	100.00	100.00
22. Telegrams (delegates)	5.12	12.00
23. Birks Pins	125.25	25.00
24. Gift	15.00	50.00
25. Bank Charges	2.00	5.00
26. Archivist-Records	—	100.00
27. Treasurer's Advance	300.00	300.00
28. Secretary's Honorarium	—	100.00
(Mrs. R. Sword)		
Membership Refunds	93.00	
TOTAL	\$7,036.52	\$6,307.00

HELP!

we need

YOU



to design a

POSTER

The Education and Recruitment Committee of the C.D.H.A. is sponsoring a contest for a poster to be designed for the "Careers in Dental Hygiene" pamphlet.

The contest is open to all members and all junior members of the C.D.H.A.

Those interested may obtain a pamphlet from the chairman.

There is a cash prize of \$25.00 for the best poster.

The deadline for the contest is March 1/72.

Posters are to:

- convey an appropriate message for the display of the pamphlet,
- be 8" x 10" - 20" x 22" on 4-ply bristol board
- be mailed to: Miss A. Kalsey,
Chairman,
633 Lodge Ave.,
Winnipeg 12,
Manitoba

RESULTS OF THE 1971 MEETING OF THE C.D.H.A. BOARD OF DIRECTORS

RECOMMENDATIONS OF THE EXECUTIVE COUNCIL APPROVED BY THE BOARD OF DIRECTORS

1. C.D.H.A. dues increase effective January 1st, 1972:

Active: from \$12.00 to \$17.00

Associate: from \$8.00 to \$10.00

Junior: from \$2.00 to \$3.00

2. Provincial associations are to consider an annual contribution to the CFDE. (ODHA gave \$100.00).

3. Due to the many trends and changes in education and legislation, provincial associations, when they have prepared a brief, response, or report, are to send a copy of the initial report to the CDHA Executive Council and each provincial candidate. The cost of sending the report is to be borne by the provincial associations.

4. New and developing associations are encouraged to contact the CDHA frequently to inform them of their progress and financial and/or organizational needs and the CDHA executive will contact these associations to advise them of the type of help available. With regards to sending a representative to the annual Board of Directors meeting and the need for financial assistance, the following factors shall apply:

(i) number of present and prospective members

(ii) cost of travel and accommodation

(iii) finances of both associations

5. All provincial associations are to consider establishing a liaison with applicable dental education institutions for the promotion and planning of refresher courses and retraining programs.

6. Delegates are to encourage and assist (or find assistance for) the formation of component societies within their associations. Existing societies are to consider organizing activities for the Annual Dental Health Week.

7. The Community Dental Health Committee are to consider ways of contributing to Dental Health Week and a file of ideas and resources compiled from various provincial committees is to be maintained.

8. The issue of mail ballots to the general membership is to be referred to the constitution committee. The Executive approves the use of mail ballots to the Board of Directors only. Consideration is to be given to have voting privileges for the President.

9. To facilitate the estimation of budgets for future officers or committee chairmen, a book containing every expenditure and subsequent reimbursement should be kept by each officer or chairman and this book should be forwarded with the file of office for that committee.

10. Each year the outgoing delegate is to meet with all those in her constituent working at the CDHA level to read and discuss the constitution and by-laws and to stress the need to incorporate these rules in all their undertakings. Meetings should also be held at regular intervals to exchange information from the CDHA Board and Executive or from the committees.

11. Funds are to be budgeted when requested and required for the purchase or rental of a typewriter for officers or chairmen whose typing load is heavy. Short term rental will also be considered.

12. Board approval must be obtained for any information identifying CDHA being released by a CDHA officer or chairman to the Press. The President may authorize interim approval. Information may be released personally, but not under her CDHA status unless authorized.

13. An honorarium is to be given to Mrs. Ruth Sword, secretary, for her work during the 1970-71 term.

14. Consideration is given to the possibility of a full or part-time executive secretary and permanent headquarters.

15. Interim reports are to be sent to the Secretary, Treasurer, and President.

16. The CDHA is to send monthly or bi-monthly newsbriefs to each constituent association to be published in the provincial newsletters.

17. Mrs. Pat Johnson is to continue to supply CDHA stationery to officers and chairmen.

18. Further investigation is to be considered for the possibility of strengthening international relations with other dental hygiene and dental auxiliary associations.

19. A subscription to **Oral Health** is available to members of the CDHA.

20. The position of CDHA Editor is to be an executive appointment, allowing the Editor to attend Board of Directors annual meeting and conventions and to receive executive mailings.

21. Nova Scotia, P.E.I. Newfoundland and New Brunswick, in co-operation with the Constitution Committee, are to give consideration to becoming an Atlantic Provinces Association until such time as Nfld., N.B., and P.E.I. have sufficient numbers to financially become independent associations.

RECOMMENDATIONS OF THE PRESIDENT APPROVED BY THE BOARD OF DIRECTORS.

1. The Membership Chairman is to look into the possibility of membership lists and mailings being handled by a company.

2. Constituent delegates are to inform at the earliest possible date the CDHA Executive and the CDA Council on Education of any colleges planning to initiate new programs in Dental Hygiene within their respective provinces.

3. The Board is to approve a policy statement on the Ad Hoc Committee on Dental Auxiliaries of the Dept. of National Health and Welfare and this statement is to be circulated to all provincial and federal governments, provincial and national dental associations and provincial dental hygiene licensing authorities.

RECOMMENDATIONS OF THE TREASURER APPROVED BY THE BOARD OF DIRECTORS.

1. As banks no longer have this policy, exchange on all out of town cheques is to be excluded. The Board requests that all out of country cheques be payable in current Canadian funds.

2. Approved auditor for the 1971-72 term:

Mr. R.D. Rogers,
Clarkson and Gordon,
Halifax, Nova Scotia.

RECOMMENDATIONS OF THE NOMINATING COMMITTEE APPROVED BY THE BOARD OF DIRECTORS.

The Board of Directors of the CDHA approves the appointment to the following positions:

President — Mrs. Linda Zambolin, N.S.

President - Elect — Miss Margery Weich, B.C.

Secretary — Mrs. Rozzi Kanigsberg, N.S.

Treasurer — Mrs. Deanna Silver, N.S.
Convention '73 — Mrs. Linda Hunter, B.C.

Board of Directors:

Mrs. Ann Anderson, B.C.

Mrs. Betty Holthe, Alta.

Mrs. Donna Anderson, Man.

Miss Linda Twible, Ont.

Mrs. Sharon Taylor, N.S.

Committee Chairmen:

Constitution — no appointment at this time

Editorial — Miss Jackie Samson, Man.

Membership — Mrs. Jo Gardner, B.C.

Nominating — Miss Margery Weich, B.C.

Education and Recruitment — no appointment at this time

Manpower and Utilization — Mrs. Karin Sipko, B.C.

Scholarship — Mrs. Gail Abel, Man.

Community Dental Health — Mrs. Meredith Wilson, B.C.

Public Relations — Mrs. Ninfa Nichol, Quebec

RECOMMENDATIONS OF THE CONSTITUTION COMMITTEE APPROVED BY THE BOARD OF DIRECTORS

1. The constitution of the Nova Scotia Dental Hygienists' Association is approved.

2. The amended constitution of the British Columbia Dental Hygienists' Association is approved.

3. A copy of the minutes of the annual Board session is to be mailed to all members of the Constitution Committee so that discrepancies in the conduct of business may be noted and commented on.

4. Each committee may form policies which will be Standing Rules for that committee only, provided that there is no conflict with the Constitution and Bylaws of the CDHA.

EXECUTIVE RECOMMENDATIONS OF THE EDITORIAL COMMITTEE APPROVED BY THE BOARD OF DIRECTORS.

1. The present editor is to continue for the 1971-72 term.

2. There will continue to be two issues of the Journal per year until it becomes more self supporting.

3. Permanent address of the CDHA will appear in each issue as 234 St. George St., Toronto 4, Ontario.

4. Encouragement is to be given to outside organizations to subscribe to or to exchange with the CDHA Journal.

5. CDHA pins and charms are to be advertised in each issue.

RECOMMENDATIONS OF THE MEMBERSHIP COMMITTEE APPROVED BY THE BOARD OF DIRECTORS.

1. The CDHA membership chairman shall have a liaison with all provincial registrars. Provincial membership chairmen shall deal with active provincial members with regard to membership lists.

2. Provinces in which there are schools of dental hygiene are encouraged to form student dental hygiene societies.

3. A change of address form is to appear in all issues of the CDHA Journal.

4. Membership kit production is to be considered even though the membership pamphlet isn't ready.

RECOMMENDATIONS OF THE SUB-COMMITTEE ON EDUCATION APPROVED BY THE BOARD OF DIRECTORS.

1. Arrangements are to be made with provincial institutional libraries to allow CDHA members to be eligible for library privileges.
2. The CDA lending library is to be encouraged to increase and modernize their volumes. The CDA Editor will offer her complimentary issues of books to the CDA library.
3. The sub-committee on education will continue to expand to include a member from each association. Members will be specifically selected for this committee.
4. The Board will approve the appointment of advisors to developing dental hygiene programs. These advisors and other members of the sub-committee on education will actively enquire into the existence of plans for proposed programs where dental hygienists are required, and will seek representation on advisory committees. Close liaison will be established with education committees of provincial dental associations, departments of education and health in order to obtain early information on projects involved with dental hygiene education.
5. Steps shall be taken to encourage the establishment of a national examination for dental hygienists acceptable to licensing agencies across Canada.

RECOMMENDATIONS OF THE MANPOWER AND UTILI- ZATION COMMITTEE AP- PROVED BY THE BOARD OF DIRECTORS.

1. Each province is encouraged to yearly review their provincial licensing by-laws and make recommendations to clarify any existing ambiguities.

2. Each provincial association should be encouraged to strive for representation on the appropriate governing body responsible for dental hygiene.
3. The committee should compile a mailing list of all organizations, individuals, schools, etc., on a provincial, federal, and foreign level to whom activities, policy statements, etc., should be sent. This information has only been received from B.C., Alberta, and Nova Scotia. Lists must be updated annually.
4. Investigation shall be considered for the circulation of a new questionnaire, the original one having been circulated in 1969.

RECOMMENDATIONS OF THE COMMITTEE ON COM- MUNITY DENTAL HEALTH APPROVED BY THE BOARD OF DIRECTORS.

1. The committee could review the materials listed by the CDA and approved by the Council on Public Health, regarding any recommendations, additions, or changes.
2. A liaison could be established between the committee and public health dental hygiene programs for exchange among hygienists of information and ideas. Encouragement could be given for hygienists employed in public health to establish a national section of public health dental hygienists with regard to possible future separate meetings at CDHA conventions.

RECOMMENDATION OF THE COMMITTEE ON PUBLIC RELATIONS APPROVED BY THE BOARD OF DIRECTORS.

1. In co-operation with the Editorial committee, consideration should be given to publishing articles in other professional journals other than those pertaining to dentistry. These others could include medical, nursing, teaching, or nutritionists' journals.

EXECUTIVE RECOMMENDATIONS FOR THE CONVENTION COMMITTEE APPROVED BY THE BOARD OF DIRECTORS.

1. The CDHA is to prepare a policy statement regarding the relationship of the CDHA Convention to the CDA Convention, stressing that the CDHA is an independent association and deals directly with the convention hotel and the CDHA convention chairman makes all convention arrangements and has total authority over them.

2. The CDHA is to be placed on the mailing list of the CDA and the CDS is to be placed on the mailing list of the CDHA to receive convention material information.

3. The executive will consider the effect on registration of late fall conventions with the possibility of future late spring or early summer conventions.

DENTISTS' GENEROSITY MAKES CFDE MONTH A SUCCESS

"Up to October 31, over a thousand of the nation's dentists have contributed to the advancement of dentistry by forwarding their donation to the Canadian Fund for Dental Education. In fact, over 200 have donated at least twice in 1971, reported the Fund's Executive Director Murray McDonald.

"\$22,591 has been personally contributed by dentists to October 31, an increase of 14% over the same period last year. If this lead can be maintained for the next two months, the minimum campaign target of \$26,500 will be exceeded by over \$2,000," said McDonald.

REFRESHER COURSE ANYONE?

"The University of Manitoba School of Dental Hygiene is anxious to determine the need for a refresher course for hygienists in the Winnipeg area, including Saskatchewan, Manitoba, Northern Ontario, Northern Minnesota and North Dakota. Hygienists interested in such a program are asked to write before January 15 to:

School of Dental Hygiene
The University of Manitoba
780 Bannatyne Avenue
Winnipeg 3, Manitoba."

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1971 C.D.H.A. CONVENTION

Dental Hygiene Faces the Challenge of Change

The 1971 C.D.H.A. Convention was held at the beautiful Skyline Hotel in Ottawa, from Thursday, September 30 to Saturday, October 2. Registration began in the C.D.H.A. Hospitality Suite Wednesday evening where a wine and cheese buffet was available to those arriving at the hotel throughout the evening.

The scientific sessions began Thursday morning with the orientation of the C.D.H.A. Advisors on Dental Hygiene Education under the leadership of Mrs. Pat Johnson and Miss Kay Kirker.

The second speaker on the program was Dr. T.M. Curry, Director of Dental Health for the province of Saskatchewan. He outlined the Dental Manpower Project in that province which uses British and New Zealand trained auxiliaries.

After a short break, panel members assembled for a discussion of the findings of the Ad Hoc Committee on Dental Auxiliaries. Moderated by Dr. R.A. Connor, recently retired Chief of the Dental Health Division, Department of National Health and Welfare, the panel consisted of members of the Ad Hoc Committee namely, Dr. A.M. Hunt, Dr. Bruce McFarlane, and Dr. Marjorie Jackson. Mrs. Marnie Forgay presented the viewpoint of a hygienist involved in education and Miss Linda Twible that of a hygienist in private practice. The seventh panel member, Dr. J.F. Reid, represented the private practitioner.

The association was pleased to have as a head table guest, Dr. Marjorie Jackson, at our luncheon following the morning sessions. Dr. W. J. Spence, C.D.A. President, extended greetings on behalf of the C.D.A., but was unable to participate further in our luncheon program due to his own convention schedule.

The association was fortunate to have a second distinguished guest in the person of Dr. Gerald Leatherman, Executive Director of the International Dental

Federation. Dr. Leatherman spoke briefly in greeting and offered encouragement to hygienists as they face changing roles on the dental health team.

The afternoon session consisted of a presentation by a three-member panel followed by an open floor discussion. Dr. R.G. Romke, Director of Dental Health for the province of P.E.I. and Mrs. Rosalyn Froehlich, a dental hygienist working in expanded duties with that province's dental manpower study, presented information of the development and operation of the public health program. Miss Kate MacDonald, Director of Dalhousie University's School of Dental Hygiene, discussed the program in expanded duties established at the university to train hygienists to work in the P.E.I. scheme. Thus all aspects of the only existing expanded duties program staffed by Canadian trained dental hygienists were explored.

We were pleased at the response on the part of members of other specialty groups in the hotel to our invitation to participate in areas of our program involving discussion of the future roles and education of dental auxiliaries. Many of the dentists from these groups (especially those in public health) attended the morning sessions and returned to hear the afternoon speakers.

The scientific sessions were adjourned in time to allow the members a little time "to put their feet up" after a strenuous, but highly informative day. For those interested, there awaited an evening at the lovely National Arts Centre where the Broln Moravian Folk Ensemble provided lively entertainment with ethnic songs and dances.

Friday's program began with seminar discussions on dental hygiene education led by Mrs. Pat Johnson and Mrs. Marnie Forgay. The second item on the program continued the topic through a panel composed of three members of the Ad Hoc Advisory Committee on the Proposed Dental Hygiene Program at Algonquin College. Dr. E.J. Fox represented

the views of the private practitioner, Mrs. Ruth Sword the position of dental hygienists and Mr. M.A. Ryant, Dean of the School of Technology, the view of Algonquin College. As the only non-member of the dental profession, Dean Ryant occupied the "hot seat" during the open question period that followed.

The final session of the morning was an informally presented and highly interesting talk by Dr. G. Kravis, Director of Dental Services for the Ottawa Board of Education. She discussed the preventive orientation of the program established by the school board and the goals they have for improving the dental health of the students under their care.

Luncheon was followed by the Eighth Annual Meeting of the C.D.H.A. conducted by Mrs. Sharon French. Mrs. Linda Zambolin of Nova Scotia was then installed as the new president.

The only speaker scheduled for the afternoon was Dr. Jean-Paul Lussier, Dean of the Faculty of Dentistry, University of Montreal. Dr. Lussier spoke on the development of the new Baccalaureate program in dental hygiene at the University of Montreal which enrolled its first class in September.

For those fortunate enough to obtain a ticket (in short supply from the C.D.A.) the evening was whiled away in the gaiety of a cabaret.

The speakers Saturday morning were two women from outside the dental profession. Dr. Helen K. Mussallem, Executive Director of the Canadian Nurses' Association, spoke of changes and developments in nursing duties and education. Many of her comments were relevant to the stresses and strains of dental hygienists facing similar changes.

Our final speaker was Mrs. Zelda Roodman, Program Manager, Bureau of Staff Development and Training, Public Service Commission, Executive Education and Management Development Division. Her topic "Women-power, the Next Step in Man-power Projects," concerned the status and rights of working women, a topic about which she was most enthusiastic.

Our final luncheon (and last official meeting together before dispersing to observe the table clinics and catch planes) was a buffet, held in warm informality in one of the spacious foyers of the National Arts Centre. Part of the luncheon program was unscheduled — the presentation of a beautiful silver bowl to your convention chairman in appreciation of her services.

For that lovely gift and for the many expressions of appreciation I received, I wish again to state my thanks. Much credit goes as well to the members of the convention committee:

Mrs. Sylvia French	Registrar
Mrs. Barbara Mark	Scientific
Mrs. Mona McLeod	Social
Mrs. Maria McConkey	Favours and prizes
Mrs. Ninfa-Anne Nicol	Publicity

and to the remaining Ottawa girls who acted as convention hostesses. Without their unfailing support and encouragement throughout the long months of planning, the convention would not have been a success. For their support and for the enthusiasm displayed by those attending, I am personally grateful.

It is my hope that the same courtesy will be extended to Mrs. Judiann Jacobson and her girls as they plan for Convention '72 in Montreal.

Next year let's surpass the attendance total for 1971 of 74 dental hygienists and 26 dental assistants (attending on a daily basis because of the lack of a national C.D.N. & A.A. program).

Miss Cathy Thom
1971 Convention
Chairman

DR. T.M. CURRY REPORTS ON DENTAL AUXILIARIES IN SASKATCHEWAN AT THE CDHA ANNUAL CONVEN- TION.

The situation regarding dental auxiliaries in Saskatchewan as it now stands is controlled by a legal act, subject to the approval of the Minister of Public Health, which may develop, regulate, and control Dental Auxiliaries (who are classified as anyone other than a dentist qualified to perform dental services specified in the bylaws and regulations).

There are three types of dental auxiliaries:

- (i) dental hygienist
- (ii) certified dental assistant
- (iii) dental auxiliaries (from Britain or New Zealand). These dental

auxiliaries perform services only with research projects and under direct supervision of a dentist provide dental care for only school age or pre-school children.

Under the present legal act in Saskatchewan, a dental hygienist **may not** —

- 1. diagnose and treatment plan
- 2. prescribe or inject drugs
- 3. cut hard or soft tissue

A certified dental assistant **may not** —

- 1. diagnose and treatment plan.
- 2. Prescribe or inject drugs
- 3. cut hard or soft tissue
- 4. deep scale
- 5. place restorations or periodontal pack

prescribe

At the Institute of Applied Arts and Sciences in Saskatoon, dental assistants are trained in x-ray procedures, rubber cup prophylaxis, and fluoride applications. Thirty students a year are enrolled in this program with an additional 80 working in dental offices and taking the course by correspondence. Final exams are written in Saskatoon.

The Oxbow Project

On the advisory board for this project are five dentists from: The University of Saskatchewan, The College of Dental Surgeons of Saskatchewan, and the Saskatchewan Dept. of Public Health. This Saskatchewan School of Dental Services Committee reports directly to the provincial government.

The Oxbow Project is currently located in the S.E. portion of the province of Saskatchewan and provides services in rural areas. It is a mobile unit which has four operatories, an x-ray unit, waiting room and clerical area. The units are completely portable, requiring only one outside connection to become operable. Children are treated up to age twelve. (2,500 children)

The mobile unit is staffed by one dentist, three certified dental assistants, and two dental auxiliaries (from Great Britain), plus a secretary and a receptionist. The unit is fully supervised with the dentist being in charge at all times. The dental auxiliary does all the operative procedures from injection, rubber dam placement, preparing the cavity through to placing, condensing, and carving the amalgam restoration. The certified dental assistant assists the dental auxiliary in her procedures and does follow-up preventive services. The dentist checks the patient at the end of his treatment and allows his dismissal. The dentist concerns himself with space maintenance and minor orthodontic procedures.

This Oxbow Project is still a feasibility project (supported by federal funds) for three to five years. After this time, federal funds will cease and the provincial government will investigate the worth and the possibility of financial support.

In Swift Current Saskatchewan, there is another project. Children, up to age 12, may receive dental care at no charge in either private or public health practice. Preventive services are provided on a year round basis.

BRITISH DENTAL ANCILLARIES

Presentation by Dr. Gerald Leatherman, Honorary President of the British Dental Hygienists Association—Skyline Hotel Sept. 30/71.

Madame President—Distinguished guests and colleagues: It is a very great pleasure and privilege to be present at our meeting and to have the opportunity to talk to you for a short time about dental hygiene in the United Kingdom, the British Dental Hygienist Association, and the British Dental Auxiliaries Association, and the British Dental Auxiliary Service.

Mrs. Wendy Leech, President of the B.D.H.A. in an excellent paper "Dental hygiene in the U.K.," presented last March at the 2nd International Symposium of the A.D.H.A. in Montreux Switzerland and published in Summer edition of "Dental Health" the Journal of the B.D.H.A. has covered the subject thoroughly and in the short time I have—will only try to give my personal views in her summary.

She states rightly that the provision of dental services under the N.H.S. has encouraged a greater demand for regular treatment. The dental attendance pattern in 1968 after 20 years of N.H.S. dentistry shows a marked change in dental attitudes. Regular attendance at the dentists of those with some natural teeth aged 16 to 34 was 45.3% and those aged 35 and over — 36% regular attendance. The younger age group who have been able to benefit from N.H.S. dentistry show a larger proportion of regular attendance.

Dental practices in the U.K. are either exclusively private (very few) or National Health Service—or most commonly a mixture of both and to alleviate the dental manpower shortage the dental hygienist was first introduced into the U.K. in 1942 and subsequently the dental auxiliary was established. Their standards of training and examinations are uniform throughout the country—and they are represented in the Auxiliary Dental workers Committee of the General Dental Council

controlled by the provisions of the Dental Act of 1957. My mind goes back 28 years to 1942 when due to the efforts of the late Sir William Elsey Fry—two of us Dental Officers in the R.A.F. wrote a course, and established a training school for Oral Hygienists and despite great opposition from the profession generally by the end of the War in 1947 the Hygienist was a useful auxiliary in the Dental Branch of the R.A.F.

In May 1949 an experimental training school was started at The Eastman Dental Hospital London—and it was at this time that the British Dental Hygienist Association came into being—22 years ago.

The British Dental Hygienists Association celebrated its 21st birthday last October 1970 when its membership was 456. Its administration has all been done on a voluntary basis, and if the Association is sound and strong today a lot of this is due to the dedicated services of its officers over the years. It has a sound constitution—is recognized by the Dental Profession as representing the Dental Hygienists—arranges good meetings and continuing education courses—and like most professional organizations requires more funds to carry out its future responsibilities.

At present there are seven civilian training schools and hospitals, three in London, two in the Provinces and one each in Wales and Scotland. There are also three schools in the Navy, Army and Dental Branches. The course of training which must be approved by the General Dental Council is one academic year, two-thirds extending over 10-1/2 to 11 months of concentrated basic science and clinical training and experience. All students take the same examinations for the Central Examining Board for Dental

Hygienists Certificate of proficiency in Dental Hygiene. All hygienists who practice must be on the Roll of Dental Hygienists maintained by the G.D.C.

At February 1st, 1971 there was 569 Hygienists on the register. In 1970 of those employed in Civilian life there were 71% in General Practice and 29% in Public Dental Service. This is because of the very comparatively low salary scale in the Public Dental Service, because in fact most hygienists say they would prefer to work in the public service. There is also a big demand from abroad for U.K. trained dental Hygienists.

The only other operative dental ancillary who is legally recognized in the U.K. is the dental auxiliary who is trained to treat children in the Public Health Service only. The training is carried at one school in Newcross—a suburb of London over a period of two academic years, and the number on the Roll of Dental auxiliaries at February 1st, 1971 was 343 of whom 217 were working. This is a significant figure—and I am afraid indicates that all is not well with the terms and conditions of work for these auxiliaries, many of whom are working in practices as chairside assistants. The specific parts of the registration which apply to Dental Auxiliaries only, show that their permitted range of work includes in addition to the hygienists duties, the extracting of deciduous teeth under local infiltration anaesthesia and the preparation for an insertion of simple dental fillings. The control and supervision is the same as for a dental hygienist in the Public Dental Service except that the specific treatment has to be indicated by a dentist in writing whereas the hygienist is simply under the direction of a dentist. Both the Government and the dental profession have become increasingly aware of the future potential demands for dental treatment and the shortage of dental manpower to deal with it.

There is no doubt that the projected shortage of dental personnel must be alleviated by increasing the number of training centres for both dentists and auxiliaries. A more effective use of auxiliaries

must include training to render selected patients care services now carried out by dentists. This means in my opinion that the Hygienists must be prepared to expand their services as soon as possible.

I believe the future will produce on two types of dental auxiliary—the non operating—and the operating—and the dental team will thus be made up of Dentist carrying out specialized services—the general Dental practitioner—the non operating auxiliary—chairside assistant and technician—and the operating auxiliary to include the Dental Hygienist New Zealand dental nurse etc.

The Dental technician could conceivably be an operating auxiliary in some countries.

I would conclude by quoting Sir John Walsh a famous dental educationist Dean of the Otago Dental School Dunedin, New Zealand. He writes:

"Dentistry is a Science and an art but dental health is a state, a part of general health. The ultimate goal of the purpose of dentistry is dental health for all people everywhere—world dental health. The responsibility for health is a shared responsibility between Government, the health professions and the people both collectively and individually.

THE P.E.I. DENTAL MANPOWER STUDY

Dr. R.G. Romcke outlines the preliminary results and the implications for the future of dental hygiene.

The graduate dental hygienist is trained for two to three months at Dalhousie University in Halifax, N.S. To date, thirteen have passed the training course. Out of twenty-five dentists in P.E.I., six were agreeable to partake in the course. Detailed records of their procedures were taken. When a hygienist, trained in expanded duties, worked in the dental office for a period of three months. Detailed records of procedures were again compiled.

Basically, the dentist prepares the cavity. He is followed by the dental hygienist who places the rubber dam, applies, trims, and wedges a matrix and if necessary, places liners in the preparation, then places, condenses, and carves the amalgam, silicate, or composite resin material.

At first the patient was moved from chair to chair as each step of the restorative process was undertaken. Finally, it was decided that the patient stay in the same chair while the dental personnel rotate. Three completely equipped operatories are needed, but there is a 50-75% increase in productivity.

In public health dental practice, the clinic is located at a school and the children are brought in. With two hygienists, 2½-3 times as many patients can be accommodated. This team approach provides complete treatment and preventive needs for 3,000 patients a year.

What about the quality of the work of these dental hygienists? Dr. Romcke states that their restorations are perfect. They are comparable or better than those done by some graduate dentists. And patient acceptance? It is excellent, he says, some people actually preferring the dental hygienist.

The University of Dalhousie has considered incorporating these expanded duties in their curriculum. The Department of National Health and Welfare has been approached for funds, but no financial support has been found. The Ontario Dental Association has been interested and has investigated the possibility of further training at the University of Toronto.

No further expanded duties are being contemplated for the dental hygienist with the expanded duties as outlined above. The reason being that the hygienist can become extremely proficient in a relatively short period of time. If there are more duties there is less speed and proficiency. Also, the necessary preventive care could get delegated to the background. As it stands now, each operator can work independently of each other.

THE ROLE OF THE DENTAL HYGIENIST IN OPERATIVE DENTISTRY

By Mrs. R. Froehlich

Dr. Romcke has outlined how the P.E.I. Dental Manpower Study has set the pace for a new concept in the team approach to dentistry. I shall try to help you visualize the actual practice of this type of team concept as seen from the dental hygienists' point of view.

Upon agreeing to participate in this Dental Manpower pilot project, two other hygienists and myself attended Dalhousie Dental College for a two and one-half month training program in restorative procedures. For the first weeks we were given lectures in Dental Anatomy and Dental Materials—most of the Anatomy was a review of our dental hygiene course but in dental materials we did a much

more extensive study of amalgams, silicates, plastic and composite resin restorations as well as of bases and temporary restorations. We then went into the lab where we carved teeth out of wax and learned how to manipulate the various dental materials we'd be using in the future.

Our first "new experience" was building up badly broken down teeth with inlay wax. We then started the operative dentistry course which was completely new (outside of polishing restorations). Working on manikins, we learned rubber dam techniques, how to apply and contour matrix bands and how to insert, condense and carve amalgam and silicate restorations. After one month we entered the clinic to do practical work for the remainder of the course. Generally speaking, a post graduate course in Operative Dentistry for graduate hygienists is as much a **review** as a learning process. A graduate hygienist is at an advantage while taking a course like this because:

1. for one—she has the academic background in the basic and dental sciences.
2. Secondly—she has developed the manual dexterity from previous training and experience.
3. Thirdly—she is clinically orientated—as she has worked on a number of patients in school and after graduation.

After our training program there was a four month practice session in a public health clinic for children. The assistants were being trained on the job, the dentist was unfamiliar with this type of team approach (as we all were!) and I was very **slow**. We tried out new routines, ideas and setups—discovered what would work, what couldn't work and what supplements we needed to make our three chair clinic efficient. I think a practice session of some sort is very necessary (whether in public health or private practice) because time and effort are required to iron out shortcomings—in setup, personal acceptance and appointment controlling.

I have worked in a public health clinic (in this capacity with extended duties) off and on for two years, as well as in various private practices and will now describe how a hygienist doing both restorative and preventive procedures can be incorporated into:

A PUBLIC HEALTH CLINIC FOR CHILDREN—For the first appointment in the morning I carry out a procedure. I can start and complete on my own. I do either a prophylaxis and fluoride or polish restorations. By the time I have finished that, the dentist has completed preparing some restorations for me to finish. I then move to that chair—where a dental assistant has everything ready to go. (If a rubber dam has not been put on by the dentist—I do so—or else isolate the area in some other way (usually use cotton rolls in one side of a pair of garment clamps) which are traditionally used for isolating the teeth for a topical fluoride).

Next—I put a base on the floor of the cavity preparation and wherever it is needed—then put cavity varnish on top of that. If it's a two or more surface preparation—I apply a matrix band around the contour and wedge it.

The restorative material—for example—an amalgam, is then mixed by the dental assistant and handed to me in the carrier. I place it in the preparation, condense it with a plugger and carve with various carving instruments. I then remove the band and dam, check for possible overhanging margins, check the occlusion with articulating paper and the restoration is completed.

If it's an anterior restoration—for example—a silicate, I contour the cellulose strip around the tooth, the assistant handles the mixed silicate, I insert it, pull the strip into place and wait for it to set. After it is set I lubricate it—a little excess is removed with a cuttle disc or finishing strip and it's complete. If there is any gross excess—silicates are finished at the next appointment. This is another procedure which can be done first thing in the morning or afternoon—as it is completely independent of the dentist's schedule.

I then move to the next chair where there are more preparations waiting to be filled—so there is a continuous moving of the operators from chair to chair.

The first appointment in the afternoon, is again an independent one—a prophylaxis, polishing or x-rays, then on to operative work. Occasionally, the dentist gets caught up doing a few extractions, so again I'd do a prophylaxis or polishing, so that I'm not idle while waiting for him to get some restorative work done for me.

In the public health clinic there is a fourth chair—called the “**preventive chair**” where prophylaxis, topical fluoride, patient education, x-rays and polishings are carried out. “The two hygienists at the clinic rotate their duties—one day she is on the three operative chairs, and the next day she is on the preventive chair—and they alternate back and forth on this.

You can see here the variety, challenge and satisfaction a hygienist would get in a system like this.

There is **variety** in preventive and operative procedures she does.

There is the **challenge** to perhaps complete a large or difficult restoration and the feeling that follows doing a job well or of having accomplished a procedure that a year or month ago seemed so difficult.

There is the **satisfaction** of feeling part of the dental team that carried your preventive procedures one step further by providing secondary prevention; namely, restorations. And the feeling of professional pride and satisfaction seems to be heightened by the fact that you are helping to bring complete dental treatment to children who otherwise would never have received any dental care other than extractions.

For six months—I also worked in various **private practices**. The general procedures for working in a private practice are similar to a public health clinic—in that you start off independently with a prophylaxis, polishing etc., first thing in the morning and afternoon appointments. An additional independent duty of the

hygienist in a private practice would be making impressions. The whole office management or appointment controlling would change along with the team concept, as Dr. Romcke has mentioned.

I'd like to point out a few things that I found different in private practice as compared to public health.

1. You wonder if patients will accept the fact that a female or hygienist will be restoring their teeth (a procedure the **dentist** has done for them for perhaps 15-20 years). In P.E.I. dental hygienists are virtually unknown of by the majority of people, because there are so few and nearly all work in public health **not** private practice. So our explanations were probably more frequent than they'd be in other parts which employ more hygienists—but on the whole, patient acceptance was very good.

2. Working on adults, as compared to children, was a great change—your patient management is so different, of course, and I often found myself talking down to adults—you have all permanent teeth, not changing dentitions—there are more anterior than posterior restorations—and there are more extensive restorations involving pin amalgams.

3. Your preventive procedures are much more extensive than in public health—we found we were very slow doing deep scaling—due probably, to our unfamiliarity with the scaling instruments in each practice and also—none of us had had any difficult scaling cases since our school days, as we'd all been on public health employ.

If you've worked in private practice before and have mastered your speed in scaling techniques and are familiar with the practice, you'll probably not find this a problem at all.

4. Our setups were temporary, the dentist, hygienist, receptionist and assistant were all experiencing something new—and trying to find the best solution to the numerous little problems that arose—for example—there is a different system of booking required and the number of restorative patients had to be controlled according to amount of output by

dentist and hygienist—and there's a lot more movement or traffic than before and so on.

Also the hygienist worked without an assistant and did all her own sterilizing and cleanups after each patient, which was very inefficient in some cases.

However, with the results of this study—one will be able to learn how and what we did to alleviate some of these problems and therefore save themselves a lot of time and effort trying to overcome them.

How do we go about getting training in restorative procedures? The best solution is to have it incorporated into the dental hygiene curriculum and I think educators are realizing this and some are acting on it.

But what about the graduate hygienist of five and ten years ago? Well, there could be graduate courses offered at the dental colleges across Canada during the two summer months when the schools aren't being used. It is felt that a two month course consisting of 44 days x 7 hours a day equalling approximately 300 hours is required to train a hygienist to do certain operative procedures.

Or—what about night classes? With two nights a week—each being three hour sessions—for a 10 month period you'd have the required 300 hours and perhaps with additional work at home the time in class could be cut down somewhat.

There would have to be an agreement with your employer that he'd be without someone for a certain period of time, and perhaps some subsidy from him to carry you through this course, and you in return could agree to work with him in this capacity of restorative and preventive work for a specified length of time, following the course.

Canada Manpower has apparently paid the tuition and some expenses for some recent graduates of the course in Nova Scotia this summer, so perhaps this could be looked into as well.

In the 1965 survey of Dental Hygienists in Canada, **75% of all dental hygienists** participating in the survey, felt that Canada's dental needs could be more completely met by expanding the duties of the dental hygienist. I think in the year since, **closer to 100%** of dental hygienists feel that the dental needs of Canada **can be better met** by expanding her duties. The who—the what—and the when of these expanded duties are causing a split in the dental profession as wide as the gap that the dental hygienist could fill.

We have proven, through this Research Project, that we are capable of doing more work—it seems apparent that we are ready and willing to do more work and I sincerely hope, that when things are settled, in regard to what will happen to our profession, we'll be able to make the theme of a near future convention. "The Dental Hygienist Accepts the Challenge of Change."

RESTORATIVE PROCEDURES FOR THE DENTAL HYGIENIST

By Miss Kate MacDonald, Director, School of Dental Hygiene, Dalhousie University, Halifax, N.S.

For the past three years, a summer course in limited restorative dentistry has been given at Dalhousie for dental hygienists. Originally, the course was designed for hygienists who were employed in the P.E.I. Pilot Project.

In June 1970, a meeting was held at Dalhousie regarding expanded duties for dental auxiliaries. This gathering was attended by representatives of dental associations, dental licensing boards and health department officials from the Atlantic provinces, as well as the National Health and Welfare Dental Consultant. A representative of the Nova Scotia Dental Hygienists' Association also attended.

After much discussion on the possible auxiliary or auxiliaries who would be assigned extra duties, the consensus of the group was that the hygienist would be the auxiliary of choice, at least in the Atlantic provinces. Also discussed at length were the possible extended duties and there was agreement that restorative procedures would be preferable to other possible duties.

As a result of this meeting, Dalhousie received a request from the Nova Scotia Dental Association last spring, asking that a course in restorative procedures were given this year that some Nova Scotia hygienists be accepted as participants. The request was granted and the Nova Scotia Dental Association managed to secure financial support from the Department of Manpower for some of the participating hygienists. It was classified as a retraining program and full support was available for those hygienists who had been graduated for at least three years. The financial arrangement included full payment of tuition, as well as a weekly stipend.

A total of seven people were enrolled in last summer's course—one hygienist from P.E.I. and six Nova Scotia hygienists, including Linda Zambolin and myself. Linda and I did not qualify for the manpower grant since we were both full-

time employees at the time. The same was true of Celia Anderson who was sponsored by the P.E.I. Dept. of Health.

The course began on June 1 and was of two months duration. The time was equally divided into pre-clinical and clinical phases. The Restorative Dentistry Department was responsible for instruction and supervision, with some assistance from Pediatric Dentistry.

In the pre-clinical phase we first reviewed dental anatomy in a series of lectures, and the inevitable carving of teeth from wax blocks. Some carving of occlusal surfaces in inlay wax on extracted teeth was also included.

Lectures were given in dental materials which were very interesting, covering information on all of the materials which we would be using.

We were all given adult and child dentofoms in which several teeth had been prepared. On these we practiced placement of rubber dam and matrix retainers, as well as the insertion, carving, finishing and polishing of restorations. The restorative materials used were amalgams, silicates, plastic and composite resins. Liners, bases and varnishes were also used.

Then we were ready for the clinic, and real live patients! However, most of us were a little frightened on that first clinic day, but we managed without having too many disasters.

A maximum of four patients were scheduled for us each day and these included both children and adults.

The procedure in clinic was to decide, with the help of one of the supervising dentists, which tooth, or teeth would be restored in that appointment. Then the local anesthetic injection was given by the dentist. While waiting for the area to become anesthetized, the rubber dam was placed, hopefully with the help of a dental assistant. However, assistants were not always available and one quite often had to put the dam on unassisted. I can now

understand why some people never use rubber dam technique! The next step was preparation of the tooth. During this procedure, the hygienist assisted the dentist. I found the assisting to be quite valuable as one became aware of what was involved in each preparation.

Then the patient was ready for the restoration and again, ideally, the hygienist would have an assistant at this time. The restoration was inserted; carved and contoured; the rubber dam was then removed and the occlusion checked. Then the instructor would see the patient again. If the restoration was satisfactory, the patient would be reappointed to have it polished, as well as any further treatment that might be necessary. I might add that hygienists were very well received by the patients, and some people indicated that they preferred having the hygienist.

From having been a participant in this course, I have a few recommendations which I personally feel would improve this learning experience.

Since the course was designed primarily to teach restorative procedures, very little time was available to do anything of a preventive nature. A solution to this, I feel, would be to carefully select the patients beforehand, so that only those who have been taught plaque control, and who were assuming responsibility for their own dental health, would be accepted.

A more workable solution, in my opinion, would be to integrate restorative procedures into the regular 2-year dental hygiene curriculum. In this way, a better balance could be achieved between the traditional dental hygiene duties and restorative procedures. It would also be possible to be more selective in choosing patients.

I also feel that since the hygienist is well-grounded in biological and social sciences that she should also be able to take part in the diagnosis and treatment planning for the patients whom she sees.

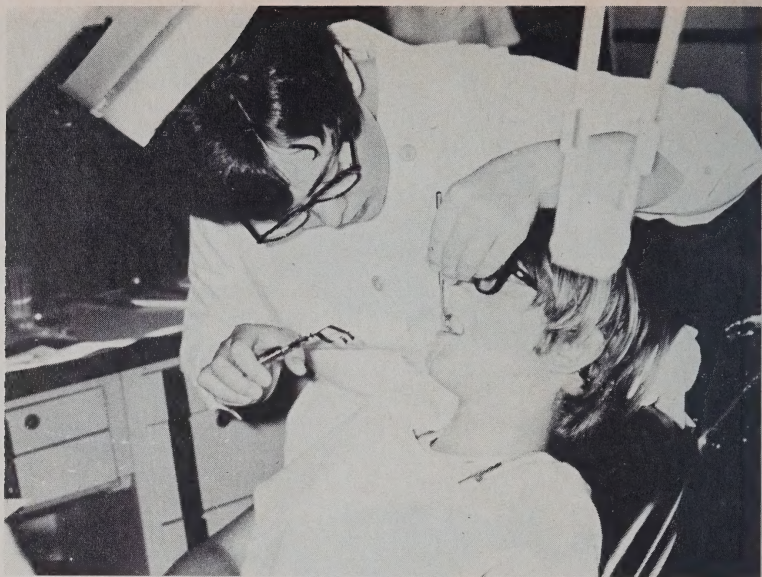
The difference between a professional and a technician is that the technician knows **how** to do a certain procedure but the professional knows **why** it is

being done. Being present during the decision-making regarding a patient's treatment would make the hygienist feel less like a robot and **more** like the professionally trained person she is.

In closing, I would like to say that I feel that hygienists must agree to further their training in extended duties, even if they feel that the traditional preventive duties are extensive enough. The problem we are now facing is the delivery of dental care and we will probably all be required to **restore** and **prevent**, at least for the next few years.



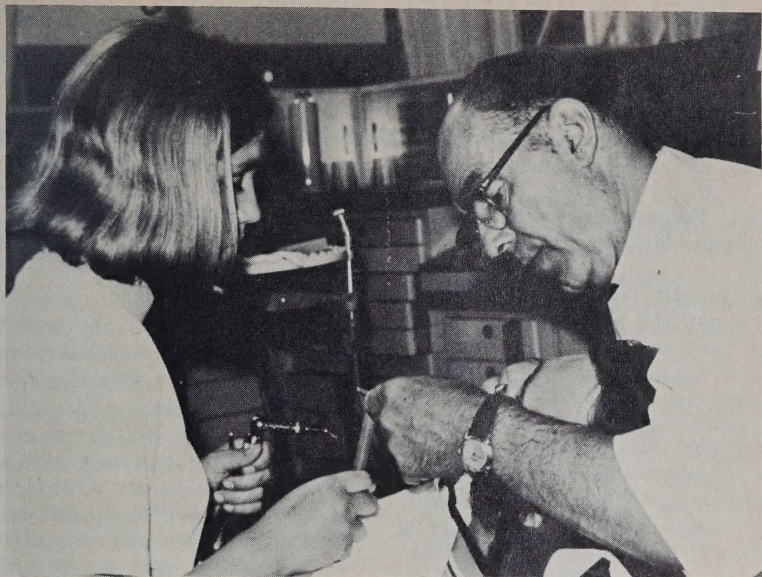
PRECLINICAL: Miss Kate MacDonald completes an Anterior Restoration.



CLINICAL: Miss Celia Anderson inserts a rubber dam clamp.



CLINICAL: Placing rubber dam. Miss Mary Louise Briggs (right) and Miss Kate MacDonald (left).



CLINICAL: Miss Bergland Blei assists Dr. C. Franklin with a preparation which she in turn will fill.

THE REPORT OF THE FEDERAL GOVERNMENT AD HOC COMMITTEE ON DENTAL AUXILIARIES

— A Hygienist's Viewpoint

Presented at the Canadian Dental Hygienists' Association Annual Meeting, September 30, 1971, Ottawa, Ontario.

By M.G.E. Forgay, Director, School of Dental Hygiene, University of Manitoba

The overall reaction of Canadian dental hygienists to the report of the Federal Government ad hoc committee on Dental Auxiliaries (Wells Committee) is strongly favorable. The general approach of the report favors greater responsibility for the three chief recognized auxiliary groups in Canada rather than the proliferation of new types of auxiliaries. It stresses the potential role of auxiliaries in the delivery of dental services to Canadians, and advocates major expansion of auxiliary training programs in appropriate settings. These things are directly in keeping with the recommendations of the Brief presented to the committee by the Canadian Dental Hygienists' Association. In fact, although the Report was, of course, more far-reaching than the Brief, there are very few points on which they are in disagreement.

In the brief time available, I would like to confine my comments to three aspects of the Report: Roles, Education, and Legislation.

1. ROLES

a) Dental Hygienists

The role proposed in the Report for dental hygienists is identical to that proposed in the C.D.H.A. Brief. Hygienists anticipate that the recommendation that hygienists be permitted to prepare cavities will be most controversial. It is significant to note that the Report does not recommend that hygienists trained to perform restorative functions be restricted to Public Health service, a restriction present for restorative auxiliaries in New Zealand and Great Britain.

b) Dental Assistants

The expansion of the role of dental assistants to encompass duties previously performed by hygienists (rubber cup prophylaxis, topical fluoride applications, etc.) is one area where there is disagreement with a recommendation of the C.D.H.A. — that the expansion of the assistant's role be related to chairside assisting of the dentist, and not be in the area of a more "independent" clinical role. However, in view of the tremendous needs for these types of preventive services, and the recommendation that these services be performed only by dental assistants who are licensed and who have completed a recognized training program, I believe that the recommendations of expanded functions for dental assistants will be acceptable to most hygienists.

c) Dental Technicians and Technologists.

The recommendations concerning dental technicians and dental technologists are of less immediate concern to hygienists than most other portions of the Report. The suggestions are basically laudable, but may be extremely difficult to implement, particularly since they would require "turning back the clock" in some provinces.

2. EDUCATION

Concerning education of dental auxiliaries, the Report makes several recommendations which are in agreement with C.D.H.A. policy: the establishment of new dental assisting programs in secondary and post-secondary schools.

locations; the establishment of new programs in dental hygiene in post-secondary institutions; the initiation of degree programs in Dental Hygiene Education to provide teachers and supervisors; bursary assistance for students; upgrading courses for auxiliaries.

I welcome the recognition of need for refresher courses for hygienists and suggest there is also an urgent need for continuing education programs for hygienists to update knowledge and teach new skills.

I question whether the phasing out of diploma dental hygiene programs in all university settings is desirable. Perhaps at least some universities would prefer a two-tier program (an approach that has been successful in other fields). This would facilitate transfer from diploma courses in other institutions and permit some desirable flexibility — for example, in requiring that those enrolling at the post-diploma level have some experience.

LEGISLATION

The most far-reaching recommendations of the Report, in my opinion, are those advising the establishment of a National Dental Program for Children, and those proposing legislative change.

For reasons of brevity, the National Dental Program for Children will not be discussed at this time except to say that such a program would have tremendous implications for improvement of dental health of Canadians and greatly extending auxiliary services in the delivery of health care. Hygienists strongly support such a program.

Concerning recommendations about legislation, these would result in having all dental auxiliaries under a legislative framework, compared to the situation now where, in some provinces, only hygienists are covered by legislation. The establishment of separate Dental Auxiliary Acts, which would delegate many regulatory functions to the three auxiliary groups is commendable. The Report does recommend de-

lineation of dental auxiliary function in both Provincial Dental Acts and Dental Auxiliary Acts, and this does not seem to be very practical. Any legislation must permit flexibility, particularly during the coming period of re-definition of roles.

The coordination of auxiliary services by means of Dental Auxiliary Councils at the provincial and national levels would ensure adequate consultation and communication on issues directly affecting dental auxiliary groups.

CONCLUSION

If hygienists have reservations about the Report, they are not about the recommendations themselves, but have to do with wondering if and how the recommendations will be implemented by those who control these matters, chiefly Provincial Dental Association and Governments. For example, if the proposals concerning dental assistants are accepted and implemented, and those concerning hygienists are delayed or rejected, the results will be frustrating for hygienists and engender defensive reactions.

However, to return to my original statement, the reaction of Canadian hygienists to the Report is strongly favorable. We will not simply wait hopefully but will work actively toward the implementation of its recommendations.

PANEL DISCUSSION ON THE AD HOC COMMITTEE REPORT ON DENTAL AUXILIARIES

by Member Miss Linda Twible, hygienist in private practice.

My position on this panel is to represent the practising hygienist and her views on the Ad Hoc Committee Report on Dental Auxiliaries. Therefore, any comments I make will be mine alone.

Dental hygienists, through the very nature of their training, have held "service to the public" as a main objective. Like many others they have seen the pressing need for dental service across the country. The hygienists, however, have been restricted in the contribution they can make to increasing the dental service available and thus decreasing its cost.

Taking into consideration the potential of the dental hygienist through her educational background and the need for dental service of the population of Canada, hygienists with vision of the CDHA made a presentation to the Ad Hoc Committee in 1968 outlining what at the time seemed pretty progressive and perhaps even "pipe-dream" recommendations for what they considered the role of dental auxiliaries in the delivery of dental service. The foresight shown in this Brief makes it recommended reading for any hygienist. In fact if I may borrow a quote from our moderator Dr. Connor made at the Conference on Auxiliary Utilization at Dalhousie University in June 1970, "I think it is the best paper we received from all the various people."

Viewing both the initial submission of the CDHA to the Ad Hoc Committee and the final Committee Report, I must consider general acceptance to be most favourable. Some of what seemed perhaps obvious to the hygienists at that time has reappeared as conclusions of this Committee. There is a marked similarity of thought between the two groups in such areas as

— expansion of duties of hygienists,

- increased programs in dental hygiene and assisting use of training facilities other than faculties of dentistry for training hygienists.
- the need for baccalaureate programs in dental hygiene
- the need for refresher and retraining programs
- the need to foster the team approach to dentistry at the undergraduate level

I would like to look at some of these points with the approach of the positive and desirable effects they will have on the working hygienist.

At present dental hygiene is a dead-end street in this country. Once a dental hygienist has graduated, she is through as far as advancing her position in dental hygiene if she remains in Canada. To work towards a baccalaureate degree, she must do so in an Arts or Science program unrelated to her field or else go to the USA. The proposal of Canadian baccalaureate programs in dental hygiene opens a whole new range of opportunities for continuing education and job opportunities as a hygienist. I think it a necessity that the opportunity for advanced education be made available for diploma level hygienists to move up the ladder if they so choose.

The dead-end street presently facing hygienists can also be relieved by the implementation of expansion of duties. I can't think of any hygienist who, with her background and experience, doesn't feel capable of absorbing greater clinical responsibilities after short term training in the new areas as outlined in the Report. I do regret seeing a cut and dried listing of duties which might tend to restrict the potential of a particular hygienist or dental office from working at their maximum potential. A dentist can't (with this list) delegate duties as he sees

it to qualified and capable members of his staff.

It has been said by many people that hygienists are over educated but I feel, like the CDHA, that under-utilized is the more appropriate term. The principle of expanded duties is a most logical method of bridging this gap between education and practical duties of hygienists and at the same time increasing office output. Working in private practice, I can see many difficulties in adapting the present office set-up to utilizing a hygienist so trained, but I can also see that the benefits to be reaped would make it worthwhile. The advantages of an advanced-trained hygienist in Public Health are still easier to visualize.

To consider retraining programs, I again see this as a must for practising hygienists. I know that the courses of study which I took have been updated considerably. Hygienists should have the opportunity to ensure that their training is open to future changes which will occur. In fact, it is even conceivable that continuing competence might at some time become a requirement for relicensure.

Even more important is a retraining program for hygienists who have not been practising for some time and wish to return to work. With the need for dental manpower, we can't afford not to have these people brought back into the labour force and working at full potential, for without doubt, their clinical work will become rusty with disuse.

The concept of teaching dental students utilization of auxiliary personnel is excellent. Through personal contact with other hygienists I hear time and time again of offices employing highly trained staff with the best of intentions and the poorest of ideas on how they can contribute to the efficient operation of the office by utilizing the greatest of their staffs' abilities. For example, no hygienist should be ordering supplies or calling patients when she could be carrying out a preventive program or procedure. This applies particularly to dentists already practising, but to prevent its continuance,

dental students are the logical ones to be started with team approach dentistry including the hygienists.

The direct effects on practising hygienists of the Proposed Canadian Council on Dental Hygiene Acts are not clear to me at this time.

The hygienist stands to gain from such recommendations as:

- government encouragement of wider employment of hygienists and all auxiliaries
- continuing research in auxiliary contributions to the delivery of dental service

Again, speaking personally, I see the Report generally as a key to wider opportunities and responsibilities for all Canadian Hygienists and I see the hygienist as completely capable of adapting to increased demands made of her. The Ad Hoc Committee Report on Dental Auxiliaries presents to the dental hygienist a marvelous challenge for an increased contribution to the total dental effort in Canada.

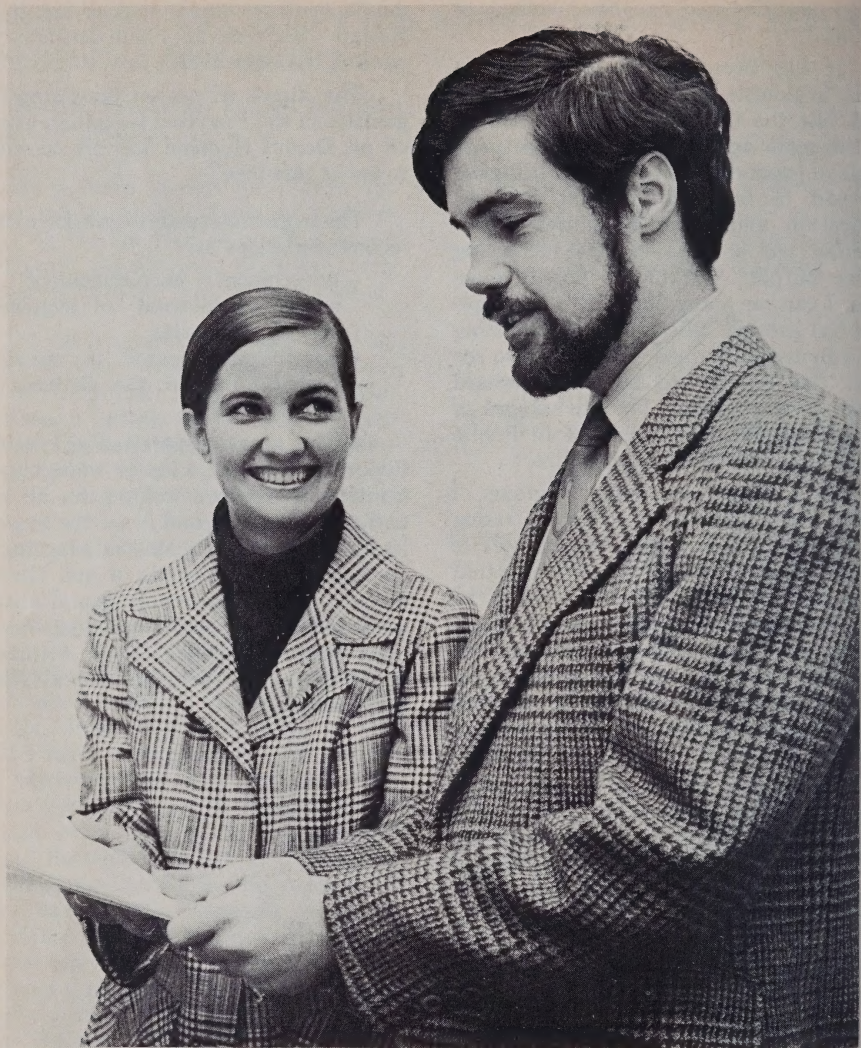


Photo: N.H.W. Information Services.

MRS. SHARON FRENCH, immediate past-president of the C.D.H.A. presents the 1971 C.D.H.A. policy statements to Mr. Tony Pearson, executive assistant to the Honourable John Munro, Minister of National Health & Welfare, Canada. The presentation took place Wednesday, October 13/71 at the Brooke Claxton Building, Ottawa.

THE CANADIAN DENTAL HYGIENISTS' ASSOCIATION ENDORSES THE STATEMENT BY THE DOMINION COUNCIL OF HEALTH ON THE REPORT OF THE AD HOC COMMITTEE ON DENTAL AUXILIARIES

The Dominion Council of Health recommends the development of new and more effective systems of dental care delivery to the Canadian people;

The Council commends Chief Justice Dalton C. Wells and his Committee on the Report of the Ad Hoc Committee on Dental Auxiliaries and endorses specifically the recommendations for the employment of dental auxiliaries. These recommendations to be implemented at the earliest possible date in order that adequate dental care may be made available to meet the needs of our citizens. It is noted that these auxiliaries would be formally trained and be permitted to carry out restorative (for hygienists, cavity preparation) plus other intra-oral procedures for which they have been trained and in accordance with the Provincial Dental Acts;

The Council also supports the proposals relating to training facilities and the establishment of licensing and control boards upon which the public and the auxiliaries will have effective representation, when taken with the attached CDHA policy statement.

CANADIAN DENTAL HYGIENISTS' ASSOCIATION POLICY STATEMENT ON THE REPORT OF THE AD HOC COMMITTEE ON DENTAL AUXILIARIES, 1970, SUBMITTED TO THE MINISTER OF THE DEPARTMENT OF NATIONAL HEALTH AND WELFARE, CANADA.

Representation of Dental Hygienists on Planning Committees in Canada

CDHA strongly recommends that any future planning committees in Canada such as the Ad Hoc Committee have representation from auxiliary groups. There were no dental auxiliaries on the Ad Hoc Committee and CDHA's recommendation that a representative of CDHA be placed on that Committee was rejected. However, members of the Committee stated verbally and in written form that the CDHA brief was one of the best prepared and presented briefs to the Committee.

Dental Hygiene Legislation

CDHA recommends that those duties, for which the respective auxiliaries are **not** to be permitted to perform, be defined in the Provincial Dental Acts. This is in accord with the current thinking of professional associations of dentists and dental hygienists across North America. However, this listing should be used as a guide to the type of duties for which the respective auxiliaries should be trained and may perform.

The CDHA does not agree with the introductory statements of Recommendations 1, 2 and 3, that serial listing of duties be defined in Provincial Dental Acts.

Statement of Philosophy Concerning Dental Services

CDHA recommends that all restorative duties be incorporated with a total preventive programme and that the education and instruction of the patients and community groups in proper home care be combined, on a continuing basis,

with the restorative duties. The restorative duties should be thought of as secondary prevention, as defined by the World Health Organization, and should not be isolated from patient education. It is recommended that the hygienist's role in education and oral prophylaxis not be lessened in importance, but that the hygienist's preventive services to the Canadian public be expanded. The provision of any restorative services without complete patient education and instruction is strongly disapproved. The prime objective should be the prevention of oral diseases. Treatment is and should be part of prevention.

C.D.H.A. PINS AND CHARMS

are available. Please write to the secretary, Mrs. Rozzi Kanigsberg, 878 Robb Street, Halifax, Nova Scotia.

A CAREER STRUCTURE FOR DENTAL HYGIENISTS

The Canadian Dental Hygienists' Association endorses the Dental Hygienists Section of the Canadian Public Health Association Report entitled, "Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada," Sixth Revision, 1970. It is recommended that a fuller Career Structure be developed for dental hygienists in public health than is currently in existence. The CPHA recommendations, along with the CDHA endorses expanded duties, should be put into force as soon as possible. It is recommended that a greater career structure be developed for dental hygienists whether in private practice, public health or elsewhere. Expanded duties should be in the consultative, supervisory, administrative fields, as well as in the clinical areas listed in the Ad Hoc Committee Report.

PREVENTIVE DENTISTRY AT WORK

—By Dr. G. Kravis, Ottawa. After graduating from the University of Toronto in Dentistry and eight years of private practice in Toronto, she is now Director of Dental Service in the Ottawa Department of Education.

This Dental Service, along with one hygienist and five assistants, is responsible for 26,000 students under the Department of Education. These students are from marginal income groups and they receive dental health education and clinic treatment.

There are three areas:

Dental Health Education (the most important part of dentistry)

- in schools
- in clinic

Preventive services

- surveys
- brush-ins
- clinics

Treatment

Dental Health Education in Schools

The dental personnel work through high school teachers as resource material. Most teachers are poorly dentally educated. The hygienist goes to every high school once a year and meets with physical and health educators. Individual instruction is given in dental health, diet, and available audio-visual aids.

The teachers then go to the teenagers in their classes and tell them:

- what to expect from a dentist
- diet and dental health
- periodontal disease
- children's dental care (for prospective parents)

DENTAL HEALTH EDUCATION IN THE CLINIC

There are three parts to this aspect, consisting of oral hygiene education, diet counselling, and the follow-up (in schools).

The patients coming to the clinic are screened by the school principals

and the school nurses. They are given a means test to determine if they are of a marginal income status.

The first appointment is with the hygienist or a preventive dental assistant. The health chart is filled in, and the patient is graded for his oral hygiene state. Then he is given a disclosing tablet and asked to view his mouth, after which he is given a toothbrush and told to brush the stain away. The child is questioned to determine the dental I.Q., whether he is interested in saving his teeth, and whether there are any personal problems he may wish to discuss. Then instruction is given on dental floss technique and the patient is given dental floss, a Crest kit, and a diet sheet, to be filled in for one week.

The second appointment is within one week. The patient is to bring with him the completed diet sheet. It is analyzed for sweet intake and nutritional value. The oral hygiene is checked for improvement. If there is no improvement, the child is told that there will be no further appointments until he wishes to help himself. Again, as before, the patient is given an opportunity to discuss any personal problems.

PREVENTIVE SERVICES

SURVEYS

Every fall, the hygienist gives a quick visual look at all grade nine students. The only equipment used is a chair, headrest, light, cold sterilizer and tongue depressors. The survey tries to establish if the patient is being looked after dentally. Forms are sent home giving the results of the visual examination. If there is no available money for treatment, the form is signed and the patient could be referred to the clinic for work.

BRUSH-INS

These are now in the fourth year of operation. Effective for large groups of people, they are cheap, simple, quick, and require little manpower. Zircate paste is used and brushing takes place for two to three minutes. Brush-ins have the support of the local Dental Society and require the written permission from the parents.

PREVENTION IN THE CLINIC

At the last appointment, the patient is given a prophylaxis, scaling, and topical application of fluoride.

TREATMENT

The aim of the clinic is to give each student the opportunity to receive dental treatment at least once during his high school life. There is such a heavy load that it is quite difficult to get work done every six months. All dental work is done, other than gold, such as: endodontics, amalgams, silicates, and composite resins, periodontal treatment, extractions, and some orthodontics, although this is limited.

TRENDS IN NURSING DUTIES AND EDUCATION

In a presentation by Dr. Helen K. Mussallem at the annual CDHA convention in Ottawa, the expanded duties of dental hygienists prompted her following observations.

Nursing, like dental hygiene, is a profession committed to providing the best possible health care. In both there are individual practitioners and both have an association to help attain this goal. Nurses, like dental hygienists, look at people as a whole person and an individual; they look at health rather than disease.

There has been considerable discussion about expanded roles. Nursing, according to Dr. Mussallem, is not an expanded role but rather a continual expanding one. Concurrently with these changes has been a move to improve education of nurses seeking diploma in community colleges. There has also been an examination of licensure and its value.

At the turn of the century, there were only four major professionals in the health service—doctors, nurses, dentists and pharmacists. Now, there are over 20 categories in the workers within the health occupations. All the original purveyors have expanded their role, and there has been a continual transfer of function from one profession to another. There are no longer fixed boundaries; all professions have continually redrawn those boundaries—some willingly—some reluctantly. If members of a profession assume their functions differ from those of other professions, they are eventually forced to recognize that this is not strict so. Only at the center is there a hard core of activities and functions that are uniquely the special competence of one profession.

The redefinition and transfer of functions is a never-ending process and each profession must work to identify the function it can discharge best. Sometimes there will be collaboration from adjacent professions—but this is not always so and one must be prepared for conflict. If a function that has been routine is transferred, it is considered a welcome change. But if this function demands skill or competence thought to be the prerogative of the profession, there may be some disagreement. However, in the transfer of function from one profession to another there is a zone of ambiguity. Society, demanding increased care, often puts pressure on the professions, and we must, as a team, provide all necessary health services and not become involved with status for ourselves. A profession that has status need not worry about its stature.

In Canada today there are two categories of nurses: those who graduate from a university degree program, and those

no graduate from a diploma program—the latter accounts for 90% of the graduates. Up to 1965, all nurses in the latter group graduated from hospital schools which offered a diploma. The training is basically an apprenticeship system and within the system the programs ranged from good to poor. In 1960, when a survey and evaluation was made of a sampling of diploma schools of nursing across Canada, in the opinion of the Board of Review who assessed the programs, only 16% met the previously established criteria of a good school of nursing.

Six years ago, all diploma nurse education was under the control of service agencies (hospitals) and was of the apprenticeship-type. During the past five years, there has been a marked increase in the numbers of students enrolling in diploma schools within the educational system (e.g., junior or community colleges, CEGEP). Today, almost 25% of the nursing students enter programs with educational institutions. Also there are other programs preparing practitioners to work within the occupation of nursing, e.g., nursing assistants or practical nurses and "psychiatric nurses."

Licensure of nurses and others in the health profession was introduced as a legal method to protect the public from incompetent practitioners. Although licensure has been useful, is it appropriate for today and tomorrow? Does it safeguard the public? What of accreditation schools? How can continuing competency be evaluated? Dr. Mussallem thinks these questions should be considered in a rapidly changing social and health structure. In ten years, she predicts, nursing will more closely resemble the practice of today's physician than that of the nurse. Even now in northern communities, nurses are assuming an expanded role that includes many activities normally performed by physicians.

Dr. Mussallem pointed out that in addition to approximately 200 diploma schools, there are 22 schools of nursing universities.

Nursing, like dental hygiene, faces the challenge of change and it also has opportunities provided by change.

THE DENTIST, THE PHARMACIST AND ORAL HEALTH

A new slide talk produced jointly by the American Pharmaceutical Association and the American Dental Association is now available for meetings of pharmacists and dentists.

The 20-minute, 78-slide program entitled "The Dentist, The Pharmacist and Oral Health," describes oral hygiene products such as toothbrushes, dentifrices, denture adhesives, reliners, aspirin and other medicaments plus giving a brief review of the oral cavity, its structure and associated diseases.

The script provides for a joint presentation by a pharmacist and a dentist, each having a speaking part. It also can be presented by one practitioner. The 35 millimeter slides are in color and include drawings and photographs. Some 100 leaflets accompany each slide kit for distribution to the audience.

Loan requests for the program should be directed to the Order Desk, American Pharmaceutical Association, 2215 Constitution Ave., N.W., Washington, D.C. 20037.



LEFT TO RIGHT: Miss Margaret Winger—Mrs. Sally Kettle, dental hygienists with the Sudbury and District Health Unit who presented a "Brush-in" table clinic at the recent Canadian Dental Association meeting in Ottawa.



Photo: United Press International.

MRS. LINDA ZAMBOLIN, President of the C.D.H.A. for the term 1971-72, left, accepts the
avel of office from Mrs. Sharon French, the outgoing president.

1972 CONVENTION IN MONTREAL

The scientific program for the Canadian Dental Hygienists' Convention will be presented June 2nd to 7th, inclusive, 1972, in Montreal, Quebec.

Papers will be presented by eminent speakers in the field who will discuss the introduction of a highly sophisticated dental hygiene approach to serving the public.

Invitations will be extended to all representatives of continentally known, interested, dentally oriented professional organizations.

Program planning has allowed time during the Convention for small groups to get together for informal discussions of varied aspects of dental hygiene with the guest speakers and professional colleagues. This will provide an unparalleled opportunity to expand your awareness of dental hygiene potentiality.

MONTREAL, Home of Man and His World, surrounded by beauty and steeped in history, is as modern as tomorrow with beautiful hotels, charming boutiques, professional theatres and vibrant and fascinating discotheques. Restaurants are many and varied, and among the finest in Canada.

MONTREAL, a bustling cosmopolitan city can justly claim to offer all that is needed to make our Canadian Dental Hygienists Association Convention a resounding success.

Come, visit the "other Canada" and enjoy its unique culture!

— Mrs. Judiann Jacobson

— 1972 Convention Chairman

PREVENTION: HOW FAR DO YOU GO? (or: How to Work Full Time and Love It)

by Miss Sherry Duncan, R.D.H. (written while in Calgary)

During the last ten years more dental research has been done in the field of prevention than ever before. Findings by the U.S. Public Health Service indicate that this is so necessary: one in four adults had no natural teeth remaining in either one or both jaws, and approximately three out of every four persons with **natural teeth** remaining showed some evidence of gingivitis or destructive periodontal disease. Also known is the fact that in the average person's mouth, if a cavity is present and a restoration is placed new cavities will develop and decay will develop around the placed restoration, **unless the environment is changed**. No matter how much effort and skill is taken in constructing a crown or amalgam, it must be placed in a caries-free environment and be maintained in this environment if long term results are desired.

These statements are well known to both dentists and hygienists and yet the horse and buggy type of dentistry consisting of drilling, filling, and extracting teeth, is still universal. Little has been done to try to eliminate reparative dentistry, which is not surprising since even the Faculties of Dentistry put more emphasis on oral surgery and dental prosthetics than on prevention and the oral prophylaxis. Few dentists, upon graduating, know how to perform a thorough prophylaxis and unfortunately only a small percentage of them will ever employ a hygienist for this vital service. In today's progressive society the dentist owes it to himself and to his patient to concentrate on:

cutting down the number of hours each patient spends in the dental chair
getting the patient to where he does not require operative treatment periodically

3) recall visits that are devoted to seeing that everything is right rather than wrong. All of this and more can be achieved with prevention.

Since September, 1969 I have had the golden opportunity of working with a dentist in developing a well-rounded preventive practice. The first few months were confusing and frustrating as we worked out the kinks in our five visit caries control program, for unless such a plan proves to be rewarding to both patient and hygienist, it will not survive. The following is a summary of what we have developed.

On the first initial visit to the dental office, the patient's medical history is checked, he is examined and necessary decay-detecting x-rays are taken. The patient is introduced to prevention when we hand him a small mirror and point out to him any areas of tartar build-up, gingival recession, obvious cavities or inflamed tissue. If the patient has any immediate dental problems (i.e. toothache) these are relieved. Last but not least, we take a Modified Snyder Test on each patient. This consists of snyder agar in a capped test tube that we pour up in the office. The patient drools about 1/4" of saliva into the tube and we incubate this for 96 hours. Four readings are taken every 24 hours, and as the blue-green agar changes color to yellow it is recorded accordingly from negative up to a four positive (++++). This measure of acidity gives us a very good indication of the environment of decay in the patient's mouth.

On the second visit the patient is presented with his treatment plan, a typed page which includes the dentist's diagnosis, treatment plan (number of cavities, estimate, number of necessary appointments) and future treatment (maintenance of six month visits, replacing

missing teeth with partials or bridges). A consultation appointment with the dentist may be necessary to explain the importance of the patient keeping his teeth for a lifetime. The patient is then in my hands for the next 60 minutes. I feel that before the patient can accept your suggestions, he must be able to accept you. Your interest in him must not be centered entirely on his oral cavity; he must feel that you are genuinely interested in his welfare and he must be motivated through your efforts to really desire to keep his teeth and look after them. Ask questions that require some thought from the patient and not just "yes" and "no" — encourage him to ask questions about his mouth. This personal involvement is necessary.

The first step in our oral hygiene instruction is, of course, staining the mouth with disclosing solution. I then give the patient a mirror and point out all the areas that are red, stressing that the non-self-cleansing areas of the teeth (where decay starts) are at the gumline, on the grooves and at interproximal areas. At this point I make up a slide, by removing plaque from the lower lingual areas of the molars and placing it on the slide with a drop of normal saline solution and a cover slip. This is temporarily set aside as I demonstrate the Bass Technique of brushing on the right side of the patient's mouth while he watches in the mirror. Most people "think" they are cleaning their teeth properly and yet are at best doing only a mediocre job. We have found that showing people how to clean their teeth by means of models or pictures is of little value. **PARTICIPATION** is very necessary. After stressing the 45 degree angle of the soft bristled brush (Tek Gentle Action) and "vibrating" on the gingival third both buccally and lingually, and then "scrubbing" the grooves, (pointing out the disappearing plaque), I hand the toothbrush to the patient and watch him brush the left hand side. This is important because few people adopt the proper stroke on the first try. The top of the tongue and cheeks are also brushed. If the patient is encountering little difficulty, I leave him brushing and place the slide under oil immersion with our

Phase Microscope. This method allows the patient to view his bacteria's fraction in the plaque without using staining techniques. Phase microscopy not only proves to be useful in engaging and motivating the patient's self-interest but puts real purpose into each individual home-care procedure. One good slide not only worth a thousand words, but also is more effective on the personally than any book, picture or film strip. After inquiring on how the patient made out in brushing and checking for missed areas, I have them get up and look into the microscope. The majority of patients have never seen bacteria magnified 1500 times and the fact that the mouth is alive with the wiggling little creatures really gives them food for thought. I explain that their saliva is measuring the amount of acid present in their mouth indicates that the bacteria plaques are producing an environment for decay. (If the tests were negative this is a basic indication, usually present in mouths with little decay but lots of tartar).

The teeth are then 50% clean. I show the patient how to use UNWAXED DENTAL FLOSS, making sure they extend it into the gingival sulcus and scrub all the way down the side of each tooth (rather than straight down and up). I point out using the x-rays how many new cavities the patient has between the teeth, out of the total to be filled, opposed to the cavities on the grooves or gumlines. (60% of decay starts between the teeth). The patient then tries the floss. Most haven't paid close enough attention and I have to review it verbally with them ("Gosh it looked so easy when you did it!"). If you ask the patient about flossing if he had a bad taste in his mouth, most of them will agree. This is a good time to impress the importance of brushing the teeth and tongue thoroughly and flossing once daily to avoid bad breath. Everyone is acutely aware of this problem — most of them chew gum or use a mouthwash to try to overcome the odor. I compare the difference to a person who smells a flower covers up with perfume or a deodorant (temporary relief) instead of getting to

se and taking a bath. These little comparisons work wonders in getting points across. If the patient has no questions, then proceed with the prophylaxis. The hygiene instruction can take up to 20 minutes, depending on how slow the patient is or how dirty his mouth is. If the patient is under 8 years of age, one of the parents (preferably mother) comes and I demonstrate and then have the parent brush and floss the child's teeth once daily, preferably before bed). If there is heavy tartar present on a patient the flossing demonstration is left until the second prophylaxis session (5 to 10 days later) and a gross scaling is done. Often in the case of Vincent's infection or acute pyorrhea, the prophylaxis must be left until the patient is able to firm up his tissues enough to allow scaling with minimal bleeding and discomfort. Warm water and salt rinses are a must in these cases.

The prophylaxis is done in one to three sessions depending on whether or not the person has ever had a thorough scaling before. Every patient receives a fluoride application and the teeth are cleaned and checked each time. The oral hygiene is marked in the chart as either poor, fair or good and in this way we can keep track of the patient's progress and also the extent we are getting through with him. On the average it takes three visits before the patient masters his weak spots in brushing and can be graded fair to good. Remembering to use the floss regularly is the biggest problem. If the patient's saliva test is positive (acidic) we give the patient a diet sheet to fill out, indicating in specific detail everything that they eat for one week, especially snacks. The patient leaves with disclosing wafers, his toothbrush, a box of P.O.H. unwaxed dental floss, and a diet sheet. He is booked again one week later.

The third visit is tied in with his restorative work and can be done while the anesthetic is taking effect. If the patient is only going through the preventive program then he is booked with me for diet analysis and O.H. check. The plaque is again disclosed and the red

areas pointed out. The patient then brushes thoroughly (Niftee disposable brushes) and flosses while I go over his diet, underlining hidden sugars in red and estimating teaspoons of sugar in the foods with the help of the pamphlet "The A B C's of Dental Decay." Other than noting if the patient's diet is well rounded with a good intake of protein and vegetable and fruit (calcium and Vitamin C also), I concentrate mainly on sweets and starchy foods. Brown bread is recommended over white, protein breakfasts vs coffee and toast, fresh fruit and non-decay producing snacks vs desserts and candy, pure orange juice vs Tang and Start (31% pure sugar), shredded wheat, puffed rice vs corn flakes, alphabets, etc. The daily sugar is totalled in teaspoons and recommendations are written out. The patient is then presented with this and the heaviest day of sugar intake is demonstrated by counting out the number of teaspoons of sugar using sugar cubes and placing them in a glass bowl. The record to date is an eight year old farm girl who had approximately 103 teaspoons sugar in one day (30 Ju-Jubes, 2 packages life savers, desserts). The areas in red are discussed and then our "Caries Control by Diet" sheet is given. This includes a list of "no-no's" in red (sweets, jams, white bread, canned fruit, peanut butter, sweetened drinks, dry cereals, etc.) that the patient must refrain from eating for three weeks. Suggested snacks are given (popcorn, carrots, nuts) and all foods permissible are printed in black as "yes-yes". Our "No-No" Sheet as we refer to it, is similar to weight watchers except carbohydrates such as bananas and potatoes are allowed.

The fourth visit, three weeks later includes O.H. check and a final saliva test. At this point the restorative work has usually been completed and amalgams can be polished. The Snyder Test takes four days before the reading is final and a motivated patient's test tube usually reads negative (still blue-green) at this time.

The dentist then makes out a brief report on the patient's final results and how he has progressed with his oral

hygiene. A fluoride mouth-rinse prescription is given to them along with this report.

If no change is recorded in the Snyder Test, the patient is then asked how closely he stayed on the restriction or how often he used the floss. There always is a small percentage of patients whose O.H. never improves substantially or who simply cannot survive without their sweets and snacks. These people are content to have their teeth drilled, filled and eventually extracted and no amount of effort on my part can convince them. Occasionally through repetition, motivation and participation a number of these individuals slowly improve over the years. Each patient at the end of treatment is put on recall for six month prophylaxis and yearly x-rays.

Who benefits from these available dental services? The list is endless. For those patients with children who want to save money and cut down their yearly dental expenses it is excellent. Prevention, for the apprehensive patient, can eliminate (or greatly reduce) the amount of drilling and filling. It will help maintain and prolong the life of ceramics and gold crowns, fixed bridges and partials (food traps) in a patient's mouth. Any diabetic patient usually finds he is eating more than enough "hidden" sugars in his diet. One patient of mine, a 17 year old male was an uncontrolled diabetic. At the beginning of treatment he even was hospitalized for a short time. We found, aside from poor hygiene and rampant decay, the patient was consuming a high amount of sugar in foods other than the obvious candy and sweets. By changing the environment of his mouth we also brought his blood sugar count under control.

Our "no-no Sheet" is a weight reducing diet for obese patients as well. The record weight loss to date during the three weeks is 22 pounds. For patients who cannot obtain treatment immediately due to financial problems or time and geography, good home-care habits and fluorides will aid in slowing down their decay process. A classical example was a sixteen year old boy who came to us a year ago with ache and at least 48 cavities.

Twelve months passed before restorative work could be started, and although the molars were beyond saving, the patient's hygiene during the waiting period improved to excellent and his tissues returned to normal. The patient visits me regularly and even bought himself a bottle of disclosing solution which he used daily with the fluoride rinse. Encouraging him to this degree we can now be assured that he very possibly will be able to keep his remaining teeth a lifetime.

Through our preventive program we can predict fairly closely whether a potential orthodontic patient is going to care for his mouth thus making the financial investment worthwhile, as well as showing the patient how to take care of his mouth while wearing orthodontic bands.

Another area for prevention is with patients who grind and clench their teeth either constantly or in their sleep. Children aged 4 to 8 years especially seem to be under pressure and cracked and chipped amalgams are common. Our argument is that a filling cannot be ground out if it isn't there, therefore we stress to parents to bring their children in at age 3 for their first dental visit. This includes O.H. instruction, fluoride tablet prescription (for Calgary) and where the primary molars are in contact, floss instruction. Nutritional good habits are emphasized.

Last is the patient who does not have the time (or does not want to miss work) to come in for treatment. By instilling good habits in this patient, we should require only two maintenance appointments per year (at his leisure). This applies to school children as well. Someone should make a study on the amount of time and work lost due to dental neglect. I am sure it would be quite an eye opener.

Our Preventive Program does not stop wholly with the hygienist. It is presented to the patient on the first visit by the dentist, and reminders are sent out every six months in the mail with the patient's status re O.H. and saliva test. These are compared at the time of the prophylaxis.

th previous records and the patient n see if he is going downhill or not. chart reads: O.H.—poor (on three oc- sions), Snyder Test—four positive and t interested in continuing with preven- on definitely indicates future problems ith little patient co-operation and more vities. The beauty of this type of set-up that just about every patient is a con- ol patient. By stressing prevention as the ajor service available in our office, we e able to readily determine those who re about their teeth, those who **can** be otivated to care for their mouths and ose patients with poor dental habits ho never will change their ways. This ormation is important in instances b observing small lesions, placing crowns, idges, splints or partials. Work that is oomed to fail should never be attempted ntil the patient's full co-operation is re- ived.

The basic ideas behind our Preventive rogram were designed by Dr. Arthur lban, a practising pedodontist in Lake- ood, California.

We would be more than happy o show anyone interested in visit- g our office and prevention set-up. emember, the dental hygienist who al- ws herself to become a mere proph machine, turning out a patient every 20 o 30 minutes, is in very sad shape in- eed. If a hygienist does not make the

time nor have the inclination to edu- cate her patient, she is of little value to either the patient or the practice.

7.3 MILLION CANADIANS DRINK FLUORIDATED WATER

As 1971 began, 7.3 million Cana- dians were using fluoridated water daily, according to the latest figures compiled by the CDA Bureau of Public Informa- tion.

These persons were served by 348 water systems which had been fluoridated, ranging from those which serve about 100 people to the water system serving over 2 million residents of metropolitan Toronto. Another 126 water systems sup- plied water containing naturally occur- ring fluoride.

Percentages of population using these supplies represent 34 per cent of the population of Canada and 46 per cent of the possible total for fluoridation (those on piped drinking water).

These and other statistics appear in the latest edition of Fluoridation in Canada as of December 31, 1970 pub- lished by the CDA Bureau of Public In- formation. Single copies may be obtained by writing to the Bureau of Public In- formation, Canadian Dental Association, 234 St. George St., Toronto 180, Ont.

A MESSAGE FROM THE MEMBERSHIP CHAIRMAN—

MRS. JO GARDNER

Beginning my third term as Canadian Membership Chairman, I have noted that for the past three years we have had an increase of approximately 100 members a year. At first thought, this seems tremendous, but then one remembers that over two hundred new hygienists graduate each year from the five schools of dental hygiene in Canada. We ideally then should be having an increase of 200 each year.

While there is a dropping of membership among those who have just graduated, there is also a disturbing drop among hygienists who have been members for many years. It is relatively easy to understand that the new graduate may not be aware of what the national professional Association does for her and her lack of understanding the need for support of the Association. It is much more difficult to understand why those who have been members through the formative years and even officers or chairmen feel there is no longer any need for their support.

It is not always necessary to give support by actively participating as an officer, Chairman or committee member. As the recognition of the national Association becomes greater, and the more tangible benefits for members increase there is also an increase in the need for more than 50% participation via membership. Even financial support by greater numbers itself can make for a strong voice for dental hygiene in Canada.

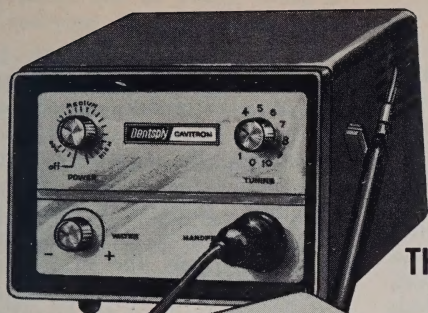
Date

NAME:

OLD ADDRESS:

NEW ADDRESS:

Member of the Association.



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NSDA PRESIDENT SPEAKS OUT ON MECHANICS ISSUE

C.E. Dexter, president of the Nova Scotia Dental Association, has spelled out his association's attitude toward the growing public acceptance of dental mechanics in his province. Doctor Dexter expressed sympathy for people to whom the cost of dentures has become a financial burden. He also stressed that many parts of Nova Scotia lack any form of dental service. But the answer to more and better dental health care, he insisted, lies in provincial government assistance to the public, not in the recognition of non-professional practitioners.

Doctor Dexter warned that dental mechanics pose a threat not only to practising dentists but also to qualified dental technicians. The latter have their own association and their own examining board. The Nova Scotia Dental Technicians Association conducts an apprenticeship training program to ensure that all technicians become proficient in all phases of their craft.

The NSDA president said dentists appreciate and rely on the skilled work of dental technicians. They respect the technical training of those who perform mechanical tasks in the making of dentures. Dental technicians, in turn, leave the clinical aspect of prosthodontics to the dental profession. But dental mechanics, who practise under neither law nor licence in Nova Scotia, undertake total clinical and technical prosthetic responsibility at costs which are aimed at eliminating professional dental fees.

According to Doctor Dexter, the mechanics are not trained to make diagnostic evaluations of the patient's needs; nor are they professionally equipped to assume responsibility for designing, fitting and placing the final appliance with due consideration for its physiological implications.

Doctor Dexter said his association insists that every citizen of Nova Scotia should have the right to seek the best possible dental care available. "To accept less than this, by turning our backs on the dental profession and the skills

of dental technicians, would constitute a grave injury to the future of dental health care in this province," he declared.

He went on to say that his association supports the recruitment of more dental students, the establishment of a new dental school, the expansion of dental services under NSI (which administers the province's medical insurance plan), the establishment of proper dental service in all hospitals, the establishment of dental prepayment plan, and expansion of training facilities for dental auxiliaries under appropriate professional supervision.

The NSDA president said his province is the only one in Canada that has no policy for the provision of dental care at any level for its citizens.

He commended a proposal to appoint a provincial dental task force and said his association would make a formal presentation by outlining a constructive approach for a proper dental care delivery system in Nova Scotia.

PROSECUTED MECHANICS PAID BY GOVERNMENT AGENCIES

Five dental mechanics in the Halifax area are said to have received a total of \$5,000 from various government agencies even though they were being prosecuted for illegal practice of dentistry at the same time.

According to a report in the September 11 Toronto Globe and Mail, payments were made by the Nova Scotia Department of Public Welfare, the Workmen's Compensation Board, and the welfare departments of the city of Halifax and the municipality of the county of Halifax. The provincial attorney-general has launched an investigation.

NEW BOOKS

CLINICAL PRACTICE OF THE DENTAL HYGIENIST 3rd Edition

Esther M. Wilkins B.S., R.D.H.,
M.D.

Published by MacMillan of Canada

This edition contains over 400 pages of detailed instructions and descriptions of techniques useful for the student, novice and graduate dental hygienist. For the hygienist who wishes to return to practice after several years of retirement, this book will serve as an explicit and up-to-date review. It is a fountain of knowledge, technical hints and specialized instructions for all phases of a modern dental hygiene practice. Additional instructions are also given for those special cases a hygienist may encounter only occasionally — viz: the epileptic, the diabetic, the retarded or cleft lip or palate patient.

Easy to read, containing numerous diagrams, figures and charts, each chapter deals thoroughly with each aspect of the dental hygienists' duties. Numerous references enable the reader to obtain additional information or explanations.

Kept in the dental office for handy reference, this book gives valuable advice for answering quickly and intelligently most questions patients may have. Almost every chapter contains a section entitled "Factors to Teach the Patient" which serves as a summary of the chapter and also offers suggestions for patient education.

It is a complete concise description of a dental hygienist's role in a dental office. Definitely a necessity for every library.

ORAL PATHOLOGY 3rd Edition

DONALD A. KERR/MAJOR M. ASH JR.

PUBLISHED BY THE MACMILLAN
COMPANY OF CANADA LIMITED

310 pages; price \$10.75

The very knowledgeable team of Kerr and Ash have again revised and improved their **Oral Pathology** text. This text is ideal for study by the student dental hygienist and also for the graduate who wishes to review her course or to further acquaint herself with a condition she may have had occasion to encounter in her practice.

Specially written for the dental hygienist, **Oral Pathology** gives clear and accurate detail of most types of common pathological occurrences. Illustrated with over 150 photographs, each significant lesion or abnormality is explained fully with a combination of text and picture.

This book has kept abreast of recent scientific developments in the study of oral pathology, for example in the chapter on hereditary disease due to additional study on genetics.

Topics covered in this text include neoplasia, nutritional disturbances, dental caries, stains and periodontal disease, all extremely important chapters for the dental hygienist.

Well written and concise, the third edition of **Oral Pathology** is worth having.

IN CLOSING... A SMILE...

The hygienist had a cold so she thought it wise to wear a face mask while working on her patients. She had just put one on in front of a young child prior to treating him when he exclaimed, "Ah, c'mon! My breath isn't that bad!"



While attempting to take a set of bite-wing x-rays on a four year old, the hygienist was having a particularly difficult time as he wouldn't co-operate and the film was constantly causing him to gag because of his squirming. Finally the little one spoke up, loud and clear, and asked the hygienist, "Are you sure you know what you're doing?"



The little four year old girl had completed her appointment with one hygienist while her mother was still being treated by a second. The daughter was allowed in the room to watch her mother and she was quite intent as she leaned over to watch the procedures. After a few minutes she said, "oooh! Mom! are they even dirty!"

Deer

The Canadian Dental Hygienist



Spring,
1972



The 1971-1972 Executive of the C.D.H.A.

President	Mrs. Linda Zambolin, Nova Scotia
President-elect	Miss Margery Weich, British Columbia
Secretary	Mrs. Rozzi Kanigsberg, Nova Scotia
Treasurer	Mrs. Deanna Silver, Nova Scotia
Editor	Miss Jackie Samson, Manitoba

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MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS

INDEX

Editorial	3
President's Message	5
About your Health	8
C.D.H.A. Convention Committee Report	9
C.D.H.A. Convention Cancelled	13
Unobtainable Goals	15
Dental Hygienists in Other Lands	20
Dental Disease Control Pamphlet	23
CFDE Report	23
The New Practice of Dentistry	25
Refresher Program Available	27
Alberta Public Health Hygienists Prepare Brief	28
Lust Control	30
Dr. Nizel Receives Grant	32
Working on the Nutrition Canada Survey	33
Positions Available	35

INDEX TO ADVERTISERS

Procter and Gamble (Crest)	4
Johnson & Johnson	7
Teledyne Aqua-Tec (Water-Pik)	14
Dentsply (Cavitron)	24
Positions Available	35

EDITORIAL

Whenever the opportunity presents itself, the Editorial will consist of a letter which I received and which I think will be of interest to the general membership. Such an opportunity is now. The letter is from Miss Sherry Duncan who wrote the article in the Fall/71 issue of this Journal, entitled "Prevention—How far do you go?" It was written while she was a practising dental hygienist in Calgary. Shortly after it was written she and a friend began to travel, and the letter I received from her was written while she was working for a short time in Australia.

Dear Jacki—

Just a short note while I'm on the ferry going to work. You asked me to write about working conditions in Australia, so I'll give you a brief idea. I can't work as a hygienist here so I'm assisting, which I really enjoy as an alternative. I was lucky to find the friendliest of dental offices and one of the biggest practices in New South Wales. There are three dentists (2 of them female) and 5 girls. I've been working here over a month and plan to leave for Asia in May. My boss is opening a new office after Easter and we will keep both the old and the new open for a while. Dr. Adey took his BDS in Sydney and his DDS in the States. His wife is American and is our receptionist, and the new dental assistant is a New Zealand Dental Health Nurse who is also unable to work at her job in Australia. If ever you are thinking of travelling here I would highly recommend it. At the moment I am in my shorts and carrying my uniform—it's a beautiful day.

Could you mail me two issues of the Fall CDHA Journal with my article in it? I have been trying to explain to Dr. Adey our preventive program and the article would be a great help. He has started a program that consists of giving tooth brushes to the patient and having him brush once a week with Floran paste (10 % SnF₂). He is keen but limited by space (one dentist/operator) and time. He often sees 30 patients a day yet his work is tops in quality. If I were to stay here I would probably get a Preventive Program room of my own to educate our patients.

Well, must run, the ferry has docked,

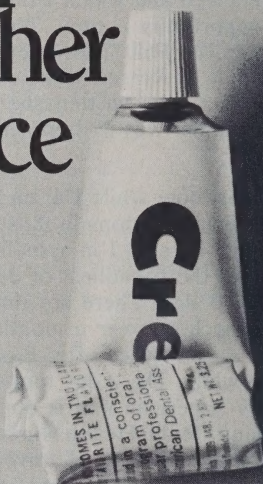
Best Wishes,
Sherry Duncan

Sherry has given me Dr. Adey's address if anyone is interested in writing to him. It is

134 Glebe Road,
Glebe, Sydney
New South Wales 2037,
Australia.

—Miss Jacki Samson,
Editor.

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1. J.A.D.A., 50:163, 1955
2. J.A.D.A., 51:556, 1955
3. J.A.D.A., 55:196, 1957
4. J.A.D.A., 58:42, 1959
5. J. Dental Res., 39:871, 1960
6. J.A.D.A., 63:189, 1961
7. J. Dent. Child., 28:5, 1961
8. J.A.D.A., 64:216, 1962
9. J.A.D.A., 65:482, 1962
10. J.A.D.A., 70:914, 1965
11. J.A.D.A., 72:392, 1966
12. J.A.D.A., 72:408, 1966
13. J.A.D.A., 73:853, 1966
14. J.A.D.A., 77:594, 1968
15. J. Canad. Dent. Assoc., 36:262, 1970

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PRESIDENT'S MESSAGE

Dear Members:

This year I have had many opportunities to represent C.D.H.A. One of the most interesting and timely experiences presented in February when I attended a seminar on the concept of Community Health Centres as a means of delivering health services.

The seminar was co-ordinated by Dr. John Hastings, Director of the Community Health Centre Project, a study initiated almost a year ago, of a year's duration to investigate the implementation of Community Health Centres in the delivery of health services to Canadians.

Dr. Bruce A. McFarlane, and his associate, Mr. Angus Reid—Department of Sociology and Anthropology, Carleton University, Ottawa, presented a paper "The Dentist, Dental Practice and the Community Health Centre" to the participants who qualified in areas of Public Health Dentistry, private practice dentistry, dental education and dental hygiene. The seminar was then based on discussion initiated by the paper.

The fact exists and has been made evident through studies that many Canadians lack dental care either because of cost or facilities and the lack of personnel available to them. Community Health Centres are a proposal of the Task Force on Health Costs, "as a means to distribute services, reduce costs and increase efficiency of first line health care."

Summary (C.H.C.P.) Participation
of Dent. in Various Types of Community
Health Centres.

Presented, February 25, 1972, Toronto.

Does dentistry have a place in a Community Health Centre? If we regard dental health as a part of total health then it can and does have a place in any delivery system for health services.

MacFarlane and Reid suggest at present that the dental profession favours individual practice to group or clinic situations which favour the team concept and while several reports have been published regarding dental health care that very few changes have been made on the part of the dental profession.

Community Health Centres have many advantageous qualities that both the community members and those being employed by the Health Centre should consider.

First of all as the name implies "Community Health Centre" this particular institution can be developed and organized to suit the needs of the community it will be serving.

One often worries when any aspect of a health service becomes part of a larger whole because it is feared this may lead to "assembly line" procedures to quote an extremely over-used expression and reduce quality and personalized care.

However the word "community" itself implies to me a collective yet personalized aspect, a "fellowship of interest," and attention to "the community" that larger institutions or smaller organizations or groups or individuals cannot attend to. This is where I feel Community Health Centres are important particularly in the delivery of dental health services.

Dental services for the most part have been delivered in a random manner and to date have served a very limited segment of the population; those in an area accessible to dental treatment, motivated to dental treatment because it has been available, those who can afford to pay for dental treatment directly without the advantage of "insurance plans" or other assistance.

We are all aware that this system has completely invaded other segments of the population who are either not accessible to dental treatment or simply cannot pay the price and who unfortunately aren't aware of the importance of dental health as a part of total health.

There are many reasons why this has happened but what must be dealt with now is a means by which the present system that most assuredly provides a valuable service can be complemented to reach the persons and areas not benefiting from dental services.

Considering availability—Community Health Centres—developed in areas away from large populated centres would not only offer a service to the residents but because of the nature of the centre, housing other professional disciplines would offer to a dentist the comradeship of other professionals like himself. Business expenditures as compared with individual practice could be decreased since certain equipment, i.e. the panorex could be considered as it would be utilized more fully to warrant the great expense for its purchase.

All pertinent information, i.e. patient history could be exchanged within the confines of the centre and such information which at times is inadequate under present circumstances would be available to the dentist as well as other services in the centre.

Many auxiliaries could be employed in such a centre to accept delegated responsibilities leaving the dentist free for more specialized skills. This system also accommodates referrals to other specialists with minimal inconvenience to patient.

Considering cost of service, as mentioned already, sharing equipment, accommodation and the adequate use of dental auxiliaries should decrease the cost to provide the service to the patient. The fact that more specialized equipment could be available and more practical in this situation, the service to the patient should definitely not decrease in quality but with the possibility of exposing a patient to experts or persons with specialized interests in other areas of dental treatment diagnosis and treatment should be nothing less than a comprehensive qualified service.

MacFarlane and Reid's paper indicates that dentistry must be accepted into the development of Community Health Centre as "full-fledged partners, not a second class citizens in the land of medicine." Through inter-professional cooperation in a Community Health Centre such attitudes could be greatly deleted and

professionals became aware of the services and **advantages** gained through association with fellow professionals.

What do Community Health Centres offer the dental hygienist? Many interesting points can be discussed. The centre employing many auxiliaries would offer to the hygienist several opportunities. Carrying out her traditional duties the hygienist would certainly be a valuable contributor to the centre. The hygienist interested in expanded duties could offer a progressive career from operator to supervisor for arranging a preventive program related to her knowledge and experience.

Because there would be several dentists and auxiliaries within the centre the hygienists' work and salary would not be interrupted by the absence of a member of the team, nor would the work of the team be interrupted by the absence of one member. This can be a considerable problem in an individual or small group practice.

In order to facilitate this concept in a profession geared to tradition certain attitudes must be changed. The dentist must consider himself in a diagnostic and supervisory capacity as well as an operator. He must be prepared to delegate responsibility to qualified auxiliaries. He must be prepared to work on a salaried basis rather than the "fee for service basis" which is widely accepted now. As well, Community Health Centres must offer to him incentive and opportunity and freedom as an individual to pursue and carry out his own contributions to the centre and of course the same applies to the dental hygienist. She must as well be prepared to supplement her preventive role with additional responsibility without detriment to either. MacFarlane and Reid suggest these changes in attitude on the part of the dentist and auxiliaries must begin during their training. Academic and clinical experiences must accommodate the Community Health Centres concept.

Community health is faced with many demands and challenges and although the Community Health Centre is not "**the**" answer to all our problems it offers a reasonable solution. What is so attractive about this concept is the fact that the problems are faced by a **team** and the team not only includes the dental profession but many other professions and each patient hopefully will be treated with equality as a significant member of his community because Community Health Centres will serve all members of the community without discrimination.

Sincerely,

(Mrs.) Linda Zambolin
President, C.D.H.A.

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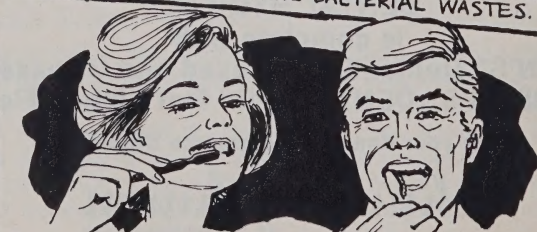
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Below is a newspaper feature column which was mailed to 2,300 small-town daily and weekly newspapers across the country by the American Dental Association Bureau of Public Information. The dental health column is part of a series issued to newspapers twice a year for use as public service features.

ABOUT YOUR HEALTH . . .

DENTAL FLOSS IS AN IMPORTANT AID IN DENTAL HYGIENE, THE AMERICAN DENTAL ASSOCIATION SAYS. MUCH TOOTH DECAY AND PRACTICALLY ALL GUM DISEASE OCCUR IN AREAS THE TOOTHBRUSH CANNOT REACH.



ALWAYS BRUSH YOUR TEETH WITH A FLUORIDE TOOTH-PASTE AFTER EVERY MEAL--ESPECIALLY AFTER SWEET SNACKS. ASK YOUR DENTIST TO SHOW YOU THE RECOMMENDED WAY OF USING DENTAL FLOSS.

ASR

C.D.H.A. CONVENTION COMMITTEE REPORT, 1972

—by Mrs. Judiann Jacobson, President, Q.D.H.A.

In mid 1970 the C.D.H.A. Executive asked if I would consider being chairman of the forthcoming 1972 Convention to be held in the province of Quebec. I accepted and slowly but surely plans for the event were formulated. In October of 1971, Montreal was chosen for the locale for the convention. The tempo of preparations was greatly increased from that point on. Publicity releases were planted in the A.D.H.A. Journal, C.D.A. Journal, constituency newsletters, and mailers of questionnaires and letters were distributed to the liaison heads in each province in Canada.

It was the intention of the Convention Committee to produce a convention which would be of timely interest to Americans as well as Canadians. Programmes and speakers were lined up. An option was taken on 75 rooms at the Sheraton-Mt. Royal Hotel in Montreal. Budget reports and recommendations were submitted to the C.D.H.A. Board of Directors in December and February, 1972. Negotiations had been completed with C.P. Air for special reductions on air fares for convention participants. C.P. Air printed 600 bulletins for this purpose. The Sheraton-Mt. Royal Hotel printed 1,000 special reservation cards to be included in the Convention Bulletin to facilitate reservations.

A separate Convention Bulletin was printed by the Convention Committee and was within hours of being distributed to all members and guests of the C.D.H.A. when the Board of Directors inexplicably renounced their support because hygienists living in the Province of Quebec were only associate members and therefore could not be chairmen of committees or hold executive positions.

I was prepared to continue on as chairman of the Convention Committee if I could receive immediate endorsement of my position by the C.D.H.A. President. After more than a month of evasion of the issue, I flew to Halifax to demand that a clear and unequivocal stand be taken by the President. In the meantime all activities were temporarily suspended. I was then informed 10 weeks before the convention that a vote would have to be taken by the Board of Directors to confirm my position. Such a vote would take three weeks. In the light of these circumstances I tendered my resignation effective March 24, 1972. Incredibly, the Executive then approached a Montreal hygienist who had no knowledge of the convention preparations to assume chairmanship, 10 weeks before the convention, of which three weeks would have been without the endorsement of the C.D.H.A. Board of Directors. She refused the position on April 6, 1972, because she had insufficient time to acquaint herself with the requirements of producing a convention. In fact, the speakers, programmes, and accommodations were complete at the point and the convention, to the committee's mind, promised to be a huge success. The response of the questionnaires and the afghan squares reflected a national interest. Inquiries were received from several persons in the United States indicating our publicity was successful. The programme provided for four innovative sessions: Junior Member Convention, Public Health Hygienist Convention, Educators Session, and an Editors Session.

As you can see, the enthusiasm with which my committee and I anticipated the convention was not based on half completed plans. Nor was my resignation based on "personal reasons" but on an administration lacking in direction and initiative.

In conclusion I would like to thank the Editor of the Journal once more for this space and I would like to thank most sincerely the people on the 1972 C.D.H.A. Convention Committee who worked so tirelessly in vain.

The following is taken from the pamphlet prepared for the Canadian Dental Hygienists' Association 9th Annual Convention, June 4-7, 1972, at the Sheraton Mount Royal Hotel, Montreal, Quebec.

Guest Speakers:

- Dr. Lussier—Dean of Dentistry,
University of Montreal
- Dr. G. Pelletier—Director of the Dental Health Division, Government of Quebec
- Dr. G. Cuzacq—Department of Preventive Dentistry, University of Montreal, Temporary Director, School of Dental Hygiene, U. of Montreal
- Mrs. Sharon French—Senior Consultant in Dental Hygiene, Department of National Health and Welfare, Past President of C.D.H.A.
- Miss Dixie Scoles—Assistant professor, Dental Auxiliary Teacher Education, University of North Carolina.
- Miss K. MacDonald—Director, School of Dental Hygiene, Dalhousie University
- Miss D. Gunther—Supervisor, Okanagan Dental Health Center, Kelowna, B.C., President of the B.C. Interior Dental Hygienists' Society
- Mrs. Linda Zambolin—School of Dental Hygiene, Dalhousie University, President 1971-1972 C.D.H.A.

- Mlle. Florence Melacon-Limoges—Supervisor Dental Assistant Clinic, Faculty of Dentistry, University of Montreal.
- Dr. B. Brown—George Brown College of Applied Arts and Technology
- Dr. R. David—Lecturer, Faculty of Dentistry, McGill University
- Dr. C. Casey—Established Preventive Practice, Affiliated with McGill Univ.
- Mrs. Pat Johnson—Co-Chairman, CDHA Sub-committee on Dental Hygiene Education, CDHA President 1969-70, and ODHA President 1971-72.
- Mrs. Z. Roodman—Program Manager, Bureau of Staff Development and Training, Public Service Commission, Executive Education and Management Development Division.

ACKNOWLEDGEMENTS FOR DOOR PRIZES

Teledyne Aqua-Tec Ltd.

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PROGRAMME

June 4, 5, 6 and 7th, 1972

Board of Directors Meetings
June 2, 3 and 4th, 1972

Sunday June 4th, 1972

10:00-12:00 Registration

12:00- 2:00 Editor's Meetings

2:30- 5:30 Educators Meetings

6:00- 9:00 Registration and Reception

9:00-12:00 CDA Reception in Hotel Bonaventure

Monday June 5th 1972

- 9:00-11:30 Table Clinics, Hotel Bonaventure
11:30- 1:30 Registration
1:30- 2:30 "Health Services in Quebec"
Utilization of Dental Hygienists in Community Health Centres
2:45- 4:00 "Employment Opportunities & Licensure in Canada"
Panel Discussion.

Tuesday June 6th, 1972

- 8:00- 9:30 "Eat and Learn Breakfast"
9:45-11:30 "Team Programme in the U.S.A. and its application in Canada"
GENERAL MEETING
12:00- 2:00 Lunch
2:30- 3:00 Results of questionnaire poll
3:00- 4:00 to be announced

Wednesday June 7th, 1972

- 9:00-10:00 Health Professions and Government Legislation
10:15-12:00 In-depth Study of a complete Preventive Programme in Private Practice.
12:00- 2:00 Lunch-Kon-Tiki Polynesian Room
2:30- 4:00 "Dental Hygiene Education in Canada—Trends today"
4:00- 5:00 Speaker from C.D.A. Society of Public Health

C.D.H.A. Society of Public Health

Monday June 5th

- 4:00- 5:00 "The Feasibility of a Society of Public Health within the C.D.H.A."

Tuesday June 6th

- 4:00- 5:00 Speaker from C.D.A. Public Health Dentists

Wednesday June 7th

- 4:00- 5:00 Programme to be announced.

C.D.H.A. Junior Member Convention

Tuesday June 6th and Wednesday June 7th

- 2:30- 4:00- Programme to be announced.

C.D.H.A. CONVENTION COMMITTEE

Chairman Mrs. Judian Jacobson
Co-Chairman .. Mrs. Sharon Aitken
Table Clinics .. Mrs. Irene Graham
Speakers Mrs. Sharon French
Publicity Mrs. Shirley Kent
Registrar Miss Dorothy Stow

Halifax, Nova Scotia
March 24, 1972

Board of Directors,
The Canadian Dental Hygienists' Association

I, Judiann Jacobson, fully cognizant of the legal and moral discrepancies presently associated with the position of Convention Chairman 1972, hereby tender my resignation as Convention Chairman 1972, effective as of March 24, 1972.

The position of Convention Chairman demands the full support of, and written mandate from the Board of Directors. This was not forthcoming. Lack of response from certain constituent associations indicated to me that the membership did not fully recognize my holding this position. Also, the duties are directly concerned with the reputation of the Canadian Dental Hygienists' Association and involves responsibility of large sums of money. Since the matter of legality is involved I feel that in order to keep matters according to the laws of the Constitution I should resign.

Any loss of time involved in obtaining the required support would result in a deterioration of convention plans and work against the interest of all members of the C.D.H.A.

Mrs. Judiann Jacobson
Respectfully signed and submitted
this 24th day of March 1972

C.D.H.A. ANNUAL CONVENTION CANCELLED

Recently several events have brought about the cancellation of our National Convention which was scheduled June 5, 6, and 7 in Montreal.

After the resignation of our Convention Chairman in March, the executive did their best to find a replacement. With only three months until Convention it was an impossibility to carry on and be assured of presenting a worthwhile program to C.D.H.A. members. It was only after much consideration that the executive decided upon the cancellation.

The executive has been in contact with the C.D.A. and are pleased to pass on the following information to you.

The Canadian Dental Association's scientific program will be open to C.D.H.A. members. Special convention badges have been prepared for our use. C.D.A.'s program runs from June 4-7, 1972. There is no registration fee.

Mr. Glover, C.D.A.'s business manager for Convention will provide us with a very limited number of convention programs. These will be distributed to your Provincial Delegate as soon as they are available. You will be able to obtain C.D.A. Convention information from her.

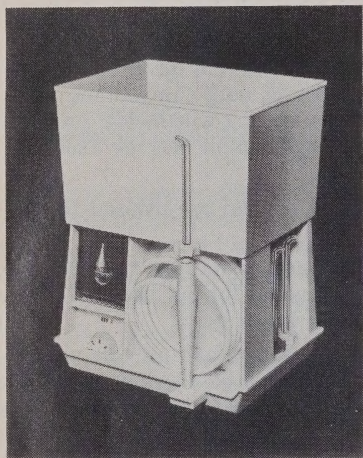
I would also like to remind you that the C.D.H.A. Board meetings will be held in Montreal either before or after the Scientific Program depending upon the C.D.H.A. Board's decision. You are most welcome to attend these meetings if you are interested.

I would like to apologize to you, the C.D.H.A. Members, for the absence of a Scientific Program this year. Please understand that it was not a satisfying nor an easy decision to have to make but the executive felt it was in your best interest this year. I hope the cancellation has not upset your vacation plans.

Sincerely, Linda Zambolin, President.

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UNOBTAINABLE GOALS

GERALD M. LATIMER, D.D.S.

The dentist just graduated from dental school has the natural tendency to develop habits of treatment that become so routine they are difficult to change in later years. The most common habit to become established is to treat only the signs and deformities that have been produced by the disease process. The tremendous amount of attention that has necessarily been given to technique and manipulative procedures during dental school almost dictates that this type of treatment pattern will develop.

Such treatment on patients of relatively high resistance to dental disease and, therefore, only minor pathology proves very successful. Unfortunately, these patients comprise only a small segment of the general practice. Those patients that have a susceptibility to dental disease and that develop dental pathology of some import fare very poorly over the years with such treatment. Treating the signs and deformities of dental disease with little or no consideration of the etiologic factors involved is to invite eventual failure for both the patient and the dentist.

Recognition of Failure

Few dentists, if any, plan the treatment of a patient with the idea of failure as the end result; they plan for and expect success. After several years of observing the results of treating only the signs and deformities of susceptible patients, most discerning dentists recognize that their failure rate is rather high. This can lead to a general feeling of frustration and a personal feeling of inadequacy. When success is expected and the only variables in the disease process that have been altered are the techniques and manipulative procedures, then failure implies that these procedures were not performed well enough or success would have resulted. This can lead to a feeling of inadequacy—perhaps even on a subconscious or non-verbal level.

After a few more years of such realized failure the dentist may begin to feel analogous to the man who has been trying to dip the ocean dry with a bucket. His personal sense of fulfillment in successful accomplishment occurs infrequently. At this point the routine of treatment planning has become rather deep-seated and it may be difficult for him to effect changes.

The Arithmetic of Disease

Dr. E. Cheraskin has devised a mathematical formula of disease that he calls the arithmetic of disease¹. This formula states that the systemic substrate factors multiplied by the exciting oral factors equal the observable evidence of disease.

systemic		exciting		observable
substrate	X	oral	=	evidence of
factors		factors		disease

This formula is very useful in visualizing that the signs and deformities of disease are on the right side of the equation sign, and that those factors responsible for this disease state are on the left side of the equation sign. It is only common sense that to attempt treatment only on the right side of the equation sign is to fail, if there is pathology of some import.

There might be some controversy over the degree to which the general dental practitioner should involve himself with attempts to correct or alter the systemic substrate factors, but I feel that most dentists could agree that counselling the patient on good nutritional habits is very much in the realm of the general dental practice.

Three Important Entities

Taking the equation of the arithmetic of disease, it follows that three things are of vital importance in the total treatment of dental disease in the individual patient. They are good nutritional

habits, good oral hygiene and good local therapy.

Counselling the patient on good nutritional habits can be as simple as informing the patient that refined carbohydrates should be avoided as much as possible, and that the diet should be high in protein².

Good oral hygiene should be based on the concepts of the daily removal of the microcosm from the surfaces of the teeth with brush, floss and, if indicated, an irrigating syringe to flush serous, cellular and microbial residue from subgingival spaces^{3,4,5,6,7}.

The importance of good local therapy needs no discussion.

The Forward Pass

Darrell Royal, head football coach at the University of Texas in Austin, has written, "But I've always felt that three things can happen whenever you throw the football and two of them are bad. You can catch the ball, you can throw it incomplete, or have it intercepted"⁸. The same might be said about the three entities of good nutritional habits, good oral hygiene, and good local therapy involved in the total treatment of dental disease. There are three possibilities and two of them are bad in the sense that they are under the direct control of the patient. The dentist can control only the local therapy; he must rely completely on the patient to practice good nutritional habits and good oral hygiene.

The practitioner who studies and contemplates the arithmetic of disease will come to the realization that when he treats only the signs and deformities of dental disease, he is really only practicing dental first-aid. It also brings the understanding that the patient has much more to do with the health of his mouth than the dentist.

A Preventive Program

For the past ten years I have had a preventive program in my dental practice in an attempt to educate and motivate my patients to practice good oral hygiene on a daily basis⁹. My success rate for the first few years was very low; I had expected it to be much higher. As I began to realize that I would not reach this high rate of success, I became frustrated. Nevertheless, I continued my preventive efforts and as the years passed, I began to realize that I had set an unrealistic—an unobtainable goal for myself¹⁰. My goal was vague since I had not put it into words or even thought about it as such, but I realized on reflection that I had been expecting a success rate of 80 to 90%. Common sense should have made me realize, originally, that this goal was unobtainable. Once I decided that a much lower rate was more realistic, my frustration began to disappear and my enthusiasm began to rise.

As the preventive program became better organized, my success rate went up a little. When audio-visual material was added, it moved up still further. As more patients learned that they could control their dental disease to a large degree, they began to refer patients to me who had already been told what prevention could achieve and were, therefore, more amenable to education and motivation than the average non-referred patient. As a result my success rate began to rise even more.

At the present time my success rate on all new patients is between 10% and 20%. Each year I add 10% to 20% of my new patients to a core of "old" patients preventing dental disease that has been accumulating over the past ten years. This is a significant group of dental patients which now comprises a good part of my practice.

So while a 10% to 20% success rate might seem low, it is realistic; it is obtainable; it is cumulative.

An Obligation

Every dental patient that presents to the dentist with signs and deformities of dental disease is entitled to a meaningful explanation of the signs and deformities of his disease, and to the information necessary to achieve as great a degree of prevention of further disease as the practitioner can give to him. Once this has been done, the patient reserves the right to make any decision. He even reserves the right to remain sick.

The Onus

This furnishing the patient with the necessary information to prevent further dental disease does something of tremendous importance for the state of mind of the dentist. It puts the onus of success or failure primarily on the patient where it belongs. It puts the dentist to the right of the equation sign in the arithmetic of disease, and it puts the patient to the left of the equation sign. And in those cases where the susceptibility to dental disease is extreme, it makes the practitioner cognizant of the fact that his very best efforts in treating the signs and deformities of the disease are probably the least important aspect in the eventual success or failure of the case.

Minimal Reparative Treatment

The patient with dental disease of some import can be placed on a preventive program for the control of the microcosm with only minimal, emergency treatment of the signs and deformities of the disease for six to 12 months. If the patient shows that he can effectively remove the microcosm from the teeth on a daily basis, then more definitive treatment such as periodontal surgery, fixed multiple restoration, removable multiple restorations, etc., can be instituted as well as the education and motivation of the patient to practice good nutritional habits.

For the patient who does not have the desire and/or ability to effectively remove the microcosm from his teeth on a daily basis, the dentist can institute

minimal reparative treatment. Such treatment reduces the possibility of adding iatrogenic factors to a case already on the downhill slide. Should the patient at some future date accept his responsibility in the prevention of his dental disease, then a more definitive treatment plan could be instituted at that time.

Repetition

Some patients can be educated and motivated to control the microcosm on the teeth in one appointment or a series of appointments within a relatively short period of time. However, many of the patients require repeated attempts at education and motivation over an extended period of time.

I have a patient in my practice that I put on my preventive program nine years ago. During the next seven years she had an average of four new carious lesions a year and continuously edematous, inflamed gingival tissues. I kept reiterating the concepts of daily germ removal, the importance of floss, etc., on each recall visit every six months. At the end of the seventh year, for some unknown reason, she responded and began practicing good oral hygiene on a daily basis. She has not had a new carious lesion in two years. Her edematous, inflamed gingival tissues improved to such a degree, and her calculus formation rate decreased to such an extent that I was able to place her on a yearly prophylaxis schedule.

It is difficult to assess how many patients on a percentage basis will respond to this long range repetition of education and motivation. However, on an individual basis success with even one patient makes the time or effort worthwhile. It does not take a great deal of time or effort to reiterate the concepts of daily germ removal, the importance of dental floss, and good dietary habits while doing a prophylaxis or necessitated operative dentistry.

The Clean Tooth God

When I first realized the tremendous results that could be achieved when patients accept and practice preventive

measures, I became somewhat disenchanted with my patients who did not achieve this high degree of prevention. I became a god of the clean tooth with the authority to sit in judgment of all that came before me for my deified observation of their mouth on their recall visits.

One patient toppled from my ecclesiastical throne and forced me to consider a distasteful conclusion. She was about 50 years of age some five years ago when I first saw her. I put her through my preventive program, but when she returned in six months on her recall visit I found that she had made no improvement at all in keeping her teeth clean. I stained her teeth with a disclosing wafer which demonstrated microcosm on all of her teeth to an appreciable extent. I was chagrined and I rebuked her for her lack of effort. I began reiterating the concepts of prevention. After several minutes I noticed a tear coursing down her cheek. I immediately stopped talking because I did not know what else to do. After a few seconds she began to sob with an increased flow of tears. I said nothing. After a minute or so she regained her composure and gave me a resume of all the personal and family problems that she had encountered in the past six months with an assurance that she would do better in the future. I can assure you that I was very humble and contrite by the time she had finished. This woman had been striving to stay in touch with reality—her teeth and her gingival tissues were the very least of her worries during that time.

This experience drove home to me with stunning impact the fact that there are patients, whole patients—psyche and cells, attached to the teeth, and that these patients possibly have problems, situations and stresses that disqualify me from sitting in judgment of them.

A Distasteful Conclusion

This experience, recounted over a period of several months, made me consider the possibility of a distasteful conclusion. Since I had decided in my own mind that my success as a dentist would

be determined by how many patients that I could influence to prevent dental disease in their own mouths, then perhaps my judging the patients so intensely might indicate more concern for my personal success than for the welfare of the patient. This might tend to make one judge patients with a degree of censure.

With the realization of this possibility I began to approach my recall patients with a completely different attitude. I decided that by repetition I would continue to educate and attempt to motivate my patients to control their dental disease, but that I would do these things on a very gentle, even humorous basis realizing that each patient reserves the right, depending on his own particular set of circumstances and attitudes, to do what he chooses or must do without censure from me.

Another Unobtainable Goal

At a Rowe Smith Seminar some years ago one of the participants stated that most dentists feel that every case they treat must be successfully treated—that every case must be placed in the box of success, neatly wrapped in dexterous fabrications, topped with the bow of excellent technique with no loose ends hanging out. I believe there is a great deal of truth in this statement.

Freed from seeking the unobtainable goal of success on every treated case, the practitioner can, with a clear conscience, attempt to educate and motivate each patient, initially and on recall visits, to prevent dental disease in his own mouth to as great a degree as possible, and to render minimal reparative dentistry to those patients who do not have this desire and/or ability.

The Transition

In my opinion the practitioner who once classified margins as good, better, and best makes the transition from dental mechanic to dentist when he begins to classify margins as poor, poorer, and poorest and attempts to the very best of his ability to educate and motivate patients to prevent dental disease in their own mouths.

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JOURNAL, July, 1971

CHANGE OF ADDRESS FORM

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DENTAL HYGIENISTS IN OTHER LANDS

by Newton E. Wickham, D.D.S. (Toronto) B.D.S. (N.Z.) of The New Zealand Society of Periodontology Bulletin. Reprinted from Bulletin No. 33, Feb./72.

Whilst New Zealand has led the world in the use of school dental nurses it has lagged in the introduction of dental hygienists. The whole situation is logically, concisely, yet adequately presented in Dr. Cunningham's article in the October/71 issue of the N.Z.D.J. It is intended that this article will be complementary, and of interest and value in outlining the extent to which these auxiliaries have been developed and integrated into the dental team in many overseas countries.

For the community their introduction in New Zealand must lead to the provision of a more comprehensive service to more people at lower cost, especially in the fields of periodontics and preventive dentistry. For the profession it will mean a reduction of some of the more monotonous aspects of our work thus enabling us to concentrate on work commensurate with our training. It will introduce a greater sense of team work and furnish stimulus and greater interest in the daily routine. Once established, dental hygienists are invariably accepted with enthusiasm by both patient and dentist.

As a decade is required to institute a training programme, graduate sufficient dental hygienists to be effective and then integrate them into the dental profession, we cannot and must not delay any longer in taking the first positive steps towards this end.

THE UNITED KINGDOM

The road to legal establishment and firm integration of the Enrolled Dental Hygienist into the dental team has been long and hazardous. In 1927-28 an abortive attempt was made to introduce "dental nurses" to scale and polish teeth and carry out minor treatments. In 1942 the Dental Branch of the R.A.F. under the direction of Sir William Kelsey-Fry and with the guidance of Fone's book "Oral Hygiene"

instituted a concentrated three month's course to train "oral hygienists." Excellent results were obtained because of the careful selection of the students, the enthusiasm of the teachers and the exigencies of war.

In 1946 the Teviot Committee recommended that a "controlled experiment" be instituted to train hygienists on a scale sufficient to test their value. Three years later the scheme was started at the Eastman Dental Hospital, London. This was continued until 1954 during which time 100 girls received one year's training and fifty-seven ex R.A.F. hygienists completed shorter refresher courses. They were permitted only to work in the Public Dental Service. The road was rough for many of them as they encountered professional antagonisms and prejudices. Although the experiment was considered a success training ceased for four years.

In 1957 a new Dentists Act made dental hygienists an established class of ancillary dental worker and permitted their employment in general practice for the first time. The field was considerably widened and gradually Schools of Dental Hygiene were started within Dental Schools in various parts of the country. By training hygienists alongside dental students, their contribution has become recognized by new generations of dentists. The last ten years have produced a marked change in professional attitudes to these auxiliaries.

The title "Dental Hygienist" is protected by law whilst approval was given in 1970 to use the short title E.D.H. — Enrolled Dental Hygienist.

Training of one academic year is provided by seven schools — all dental training schools — three in London and one each in Birmingham, Manchester, Cardiff, and Edinburgh. There are also training schools attached to the Royal Air Force, Royal Army Dental Corps and the Royal Navy. They vary in

accommodation from six to twenty, with a total output of about 100 a year.

Because of the concentrated nature of this course it is important that the students have previous chairside experience and possess good academic standards. The excess number of applicants presenting means that the schools are able to be selective. Tuition is free and a government maintenance grant is paid to U.K. students. Foreign students have been accepted from Sierra Leone, Ghana, Sweden, the Netherlands, Spain and Finland.

Distribution of Dental Hygienists, March '70.

General Dental Practitioners.....	193
Hospital Service	54
Local Authority Dental Service .	26
Armed Forces	19
Overseas	28
Not at present working as hygienists	93
Not stated	41
Total (including 16 men)	454

Total number on Roll of Dental Hygienists Feb/71 569

Scope of Work

1. Scale and polish teeth — removing both sub and supra gingival calculus, stains and black copper cement; (polishing teeth includes teeth previously filled or otherwise restored. This is a new feature of the curriculum which was only introduced in 1970).
2. Application of topical fluorides.
3. Application of desensitizing agents.
4. General assessment including charting measurement of pocket depth.
5. Taking and processing dental radiographs.
6. Removal of periodontal packs and sutures.
7. Irrigation of the mouth.
8. Giving oral hygiene instruction and dietary advice to each patient, and dental health talks to various age groups.

The British Dental Hygienists'

Association was founded in 1949 — before the British and N.Z. Societies of Periodontology! — the membership in August 1971 being 466. This is a dedicated and active association. In addition to the excellent publication of "Dental Health" issued quarterly, a newsletter is sent to members approximately eight times a year. This keeps members informed of meetings, council activities, changes of address, marriages, births, and vacancies. Speakers are invited to read papers at the AGM in November and the spring meeting in March. The council meets 6 - 7 times a year. The Honorary President is Dr. G.H. Leatherman, the president Mrs. W. Leech, E.D.H., 15a Georges Wood Road, Brookmans Park, Hatfield, Herts., the Secretary Miss Ann Round, E.D.H., Tutor Dental Hygienist, Royal Dental Hospital School of Dental Hygiene, St. Georges Hospital, Tooting Grove, London, S.E. 17.

CANADA

The first school of dental hygiene was established at the University of Toronto in 1951 and between 1953 and 1962 it produced between five and sixteen graduates a year. In 1963 this dental school more than doubled its output whilst schools at Dalhousie University and the University of Alberta graduated their first hygienists.

These were followed in 1965 by the University of Manitoba and in 1970 by the University of British Columbia. The total number graduating in 1970 was 110, with the total of registered dental hygienists in January 1971 standing at 776. A precedent has been established in that at least one male student is currently enrolled in Toronto.

The curriculum offered in Canadian schools of dental hygiene during the 1960's included functions traditional to the United States: prophylaxis radiography, education, public services, topical fluoride application, polishing restorations, charting and history taking. One notable exception was the clinical programme in prosthetic dentistry at the University of Manitoba which

included instruction in taking impressions for full dentures, mouthguards and study models as well as registration of bite relationships.

The present diploma course is two years duration and is provided at University Dental Schools. However recommendations made by the Ad Hoc committee on Dental Auxiliaries (1970) include the establishment of diploma programmes at post secondary institutions with a phasing out of the University programmes. Bachelor's degree courses of four years in Dental Hygiene would be developed in universities to provide necessary teaching and supervising personnel. This committee also recommended that dental hygienists be trained and permitted to extend their scope to such functions as placing temporary sedative dressings, taking impressions for study models, placing and finishing amalgams, silicate and plastic restorations, placing matrix and orthodontic bands and repairing dentures.

The Royal Canadian Dental Corps utilizes the services of the Dental Therapist or Clinical Technician. Having been trained and then functioned for 3½ years as a dental hygienist in the Corps, this person may take a 14 week course which enables him to perform additional duties such as applying rubber dam, placing and finishing amalgam, silicate and acrylic restorations, taking impressions for study models and dentures, and placing periodontal packs.

The Canadian Dental Hygienists' Association was formed in 1963 and now has almost 600 members in all ten provinces. There are also six provincial associations. The national body publishes "The Canadian Dental Hygienist" twice a year and holds an annual convention. The permanent mailing address is 234 St. George St., Toronto 5, Ontario.

THE U.S.A.

The U.S. were easily the first to introduce dental hygienists. They did so in 1915 and by 1951 all states had statutes for licensing auxiliaries. At pre-

sent there are 6,000 students enrolled in 122 training schools and there are over 24,000 practising hygienists.

AUSTRALIA

Dental personnel in the Royal Australian Navy, Air Force and Army who have taken a sixteen weeks full time training course to become chairside assistants may pursue a further seventeen weeks full time course to qualify as dental hygienists. This course is provided at H.M.A.S. Cerberus and includes tuition in oral prophylaxis, dental health education, radiography and basic medical sciences. Fifteen completed training in 1970 whilst there were sixteen undergoing training in 1971.

In 1971 the Western Australia Institute of Technology in Perth launched its two year diploma course to train dental therapists to treat children and adults in either State Government or private practice. This course includes dental technology, clinical dentistry (2 years), English, human biology, histology, bacteriology, histopathology, clinical chemistry and pharmacology. In 1971 there were fifteen participants.

SWEDEN

Sweden, which incidentally boasts the highest ratio of dentist to head of population (1 to 1,000), commenced training dental hygienists in 1968. The school at Malmo accepts sixteen trainees per year and the one at Orebo eight, there being some fifty graduates practising in that country. Applications for the one year course are accepted from girls who have undergone two years training as dental nurses followed by two years employment as chairside assistants. The course is an exacting one and great emphasis is placed on physical stamina. It includes one hour per week spent on physical exercise.

SWITZERLAND

In 1965 the law was amended to permit dental hygienists to practise and plans are now well advanced to open a training school in Geneva in 1972. Six students will be accepted for the first

two year course. Pending the opening of this school hygienists have been imported from the U.S. and Canada.

JAPAN

Dental Hygienists were introduced in Japan in 1948. There are now over 5,000, trained in sixty-three schools providing either one year or two year courses. 80% are employed in private practices, 10% in hospitals and the remainder in schools and public health centres.

SOUTH AFRICA

This country is in a similar position to New Zealand. The Dental Council has recommended registration of Oral Hygienists, but in spite of intensified representation no training programme has been introduced.

Acknowledgements:

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Bulletin Nos. 17 (Alan Laws), 26 (David Barker), 27 (Wendy Burgess).

DENTAL DISEASE CONTROL PAMPHLET OFFERED BY EINSTEIN COLLEGE

A pamphlet on Plaque Control containing material useful in motivating and educating patients about prevention and treatment of the dental disease is being offered by the Albert Einstein College of Medicine to general practitioners and specialists in periodontics.

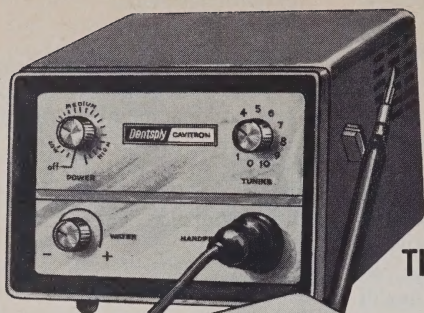
The 12-page illustrated, two-color pamphlet may be obtained by sending 50 cents in coin to:

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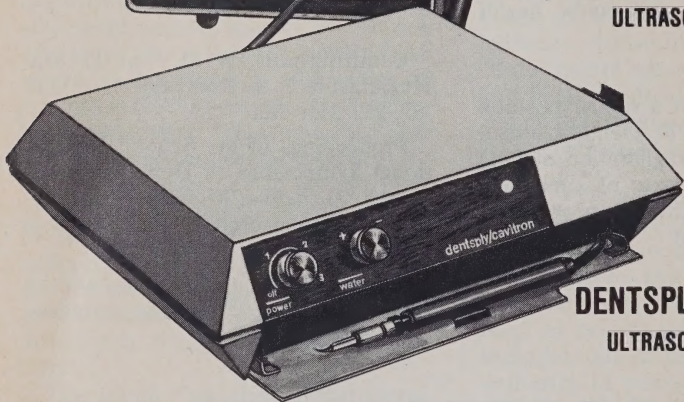
CFDE INCOME EXCEEDS \$100,000 FOR FIRST TIME

TORONTO (February 3, 1972) — Canadian Fund for Dental Education receipts in 1971 totalled \$104,996, a new all time high and a 15.4% increase over the previous year, it has just been announced by Mr. Charles E. Peirce, Vice-Chairman of the Fund's Board of Trustees.

"Contributions from both dentists and business firms moved sharply ahead with respective increases of 20% and 28%. This substantial improvement in support is most encouraging and will enable the Trustees to do an even more effective job of moving dentistry up," said Mr. Peirce.



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THE NEW PRACTICE OF DENTISTRY

Irving Glickman, D.M.D.

tufts University School of Dental Medicine

Alumni Day

March 4, 1972

I am taking this occasion to speak about prevention in dentistry and its implications for the oral health of the nation because, in addition to being expert in the art and science of dentistry, you should be aware of what is going on in the relationship between the profession and the public, which it is franchised to serve. It seems apparent from all that is being written and said that changes are going to take place in our profession. In the final analysis the profession itself is most qualified to make these changes, but its members must know what is going on before they can actively participate in doing what is in the best interest of the public's oral health. However, most practitioners are too busy taking care of the needs of their patients to spend the time to study the direction their profession should be taking. Those who have the time should gather the information and bring it to the attention of the profession.

It is quite a paradox that our profession, which over a quarter of a century ago developed fluoridation, one of the most significant developments in the field of preventive medicine, should suddenly find itself the target of evangelistic preaching regarding the importance of prevention as if it were something new to dentistry.

The idea of preventing disease is not new — the idea that teeth should be cleaned is not new — the idea that bacteria form plaque on teeth and that plaques should be removed is not new.

What is new is that prevention has finally come into its time. The emphasis on prevention in the last eight years is a symptom — a symptom of dissatisfaction on the part of a vocal segment of the profession and its leaders with the discrepancy between the mission that dentistry is enfranchised to perform, and the status of the nation's oral health.

Just how bad is the disease of which this urge for prevention is a symptom?

According to various studies there are 5 billion unfilled cavities in the United States. Three out of four teenagers have gingivitis, 50% of the adult population has pyorrhea, 20 million people have lost one-half their natural dentition, another 25 million people have no teeth at all. There will be 23,000 new oral cancers in the United States this year, many will not be caught early enough so that there will be 5,000 deaths.

In order for the practice of dentistry to change so that it best meets the public need. One of the first changes that must take place is in the educational program which prepares people to serve the public.

Our universities have made a monumental contribution to the teeth of the American. Instead of the approbation of grateful state and federal governments it is faced with support which is in diminishing proportion to the mounting task before it. Reducing expenses and balancing budgets have snatched the priority from improvements in health service education that our country so sorely needs. The universities would be the first to admit that a program which does not meet the needs of the public is too expensive regardless of how penuriously it can be provided. The times call for courageous, imaginative developments in dental education and it is hoped that public and private sources recognizing it is in their best interest to do so, will earnestly support them.

Universities have a great influence on the oral health of the public. By what

it teaches the dental student, the university casts the die for the dental care of the public for generations to come. An educational system with responsibility for training professional men and women to serve the public must first determine the nature of the task for which they are training these people.

What has been the history of our dental education? The first dental school was created in Baltimore in 1840. It had a faculty of four, a student body of five, a curriculum of 16 hours and a first graduating class of two. The venerable founders of our dental educational program could not have envisioned the scope of dental service required today. The past 130 years have seen a steady growth in the infant curriculum of 16 hours. By 1920 two dental schools expanded their programs to four years, and in 1922 the country went on the two (college) — 4 year (dental school) plan which has been with us for 50 years, except for the addition of two and three year specialist training programs in the 1950's.

There is now a general trend toward shortening the curriculum. The length of the curriculum is not the problem in dental education, it's the content. In the past hundred years we have lengthened it and patched it so that it bears little resemblance to the public's need to which it must be tailored. The time has arrived to stop patching and start anew — to take a new measure of the public requirements — and design a new curriculum accordingly.

We keep talking about flexibility in dental education when what we need is direction. Dr. Hamilton B.G. Robinson, Member of the Council on Dental Education of the American Dental Association and Dean of the University of Missouri-Kansas Dental School, in a paper entitled "The Challenge to Dental Educators — 1971," which appeared in the *Journal of Dental Education* (February 1971), had this to say: "Our clinical teaching must emphasize the responsibility of the dentist for continuing and comprehensive care of his patient rather than the episodic treat-

ment of carious lesions, periodontal inflammation or stomatitis as they happen to occur. The entire framework of the teaching of the practice of dentistry must change and it must start with prevention in the dental schools."

Dr. Robinson goes on to say, "We cannot just reproduce dentists in the image of their teachers. We need to motivate faculty members to develop a new breed of dentists who are not cast in the molds of the past."

Ladies and gentlemen, the mold of the past was repair. The time has come when the teaching of dentistry must abandon its preoccupation with repair and concentrate on prevention. Meaningful experimentation should be built into our educational program.

The time has passed when one type of dental school can do justice to the education of practitioners, researchers, educators and dental administrators. Instead of a single dental schools it may be time for regional multicentric dental centers with graded facilities for preparation of all oral health personnel from the dental assistant to the esoteric scientist. The responsibilities of educational programs can no longer terminate with the preparation of practitioners. We have witnessed the gap that can develop when public need mushrooms beyond provision at the source to take care of it.

What does the new dentistry mean to the dental practitioner? There is an entirely new concept of what constitutes the practice of dentistry. Dentistry's mission under its franchise is now clearly defined in the prevention of oral disease — and secondarily the repair of diseased tissues. We are no longer to be a repair program — even if we try to camouflage it with a few sprigs of preventive dentistry, a little plaque control, or topical fluoride.

For all patients in all practices the first service must be prevention — and the disease which we cannot prevent we shall repair.

Yes, we have a big backlog of untreated disease. But we cannot continue to concentrate on the results of

the disease rather than prevention because the backlog will keep getting bigger and bigger and we will become less and less able to cope with it.

Which brings us to the final, but most important aspect of the new practice of dentistry. We must place a new number one priority on research. Our profession is challenged by the two most prevalent diseases of mankind. The answer to their prevention lies in research. We have taken a great step in the caries field; it must be matched and exceeded in periodontics.

Our profession and the American public need a strong echelon of researchers, in an intellectual, economic environment in which they can flourish and produce. We must match them with practitioners anxious to utilize the findings of research laboratories and clinics for the chairside prevention of oral disease.

THE UNIVERSITY OF MANITOBA School of Dental Hygiene REFRESHER PROGRAM IN CLINICAL DENTAL HYGIENE PRACTICE

This course is designed to assist hygienists who have not been in clinical practice for some time, to renew clinical skills and update knowledge in areas closely related to dental hygiene practice.

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Fee: \$50.00

Final Date of Registration: July 1, 1972

Staff: Mrs. M.G.E. Forgay
Miss I.L. Gold
Dr. D.B. Proctor, Supervising
dentist

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If you wish further information, please contact:

Mrs. M.G.E. Forgay, Director
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ALBERTA PUBLIC HEALTH HYGIENISTS PREPARE BRIEF

The following is a brief prepared by Alberta Public Health Hygienists. It was organized as each discipline was requested to submit briefs to Mr. N. Crawford, newly elected Minister of Health. Some of the pertinent points include present program, suggestions for improvement, etc. This particular brief was used in part, not verbatim, by Dr. P. Finnigan, Dental Health Officer, Leduc Strathcona Health Unit.

CANADIAN PUBLIC HEALTH ASSOCIATION COMMITTEE

DENTAL HYGIENIST'S SUBMISSION

The dental hygienist is primarily concerned with the prevention of dental disease and maintenance of good oral health through a variety of educational and certain prevention-oriented clinical procedures. Presently, there are 43 dental hygienists employed in Health Units throughout Alberta. The dental health programs are delivered, and in part planned and administered by these hygienists. Although the programs vary in approach and emphasis, the following services are generally carried out:

i. Clinical

- a) Scaling and polishing of teeth
- b) application of topical fluoride solution
- c) organizing of group fluoride therapy

These procedures are generally limited to school and pre-school children.

ii. School

- a) dental examinations and referrals
- b) clinical services
- c) classroom demonstrations
- d) individual oral hygiene instruction
- e) career presentations

iii. Parent Consultation

- a) in conjunction with clinical procedures
- b) following school examinations

iv. Fluoride Supplement Program

for those without the benefit of fluoridated water.

Each part of the program requires careful planning and organization which is also the responsibility of the dental hygienist.

Because there is a need for a broader and intensified dental service to the Canadian people, certain changes are expected. Trained dental auxiliaries will be in demand to carry out expanded service. Here, the public health dental hygienist feels she has an important part to play.

The Graduate Public Health Hygienist Would Like to Expand Her Duties To Include The Following:

1. Restorative procedures
2. Placing of space maintainers and orthodontic bands
3. Other duties which may from time to time be approved by the provincial licensing bodies
4. Intensified community and school education backed by a solid grounding in educational methods, and behavioural sciences.

In order to carry out these additional services, the following should be provided:

1. Refresher and retraining programs as soon as possible
2. Appropriate scheduling of these programs, e.g. during the Summer months and Winter evenings.
3. Opportunities and assistance granted by local Boards of Health to attend programs
4. A Bachelor's degree program providing the hygienist with both clinical and theoretical knowledge to provide supervisory and administrative personnel for dental health programs, and to provide educators for other auxiliary training programs.

Both degree and retraining programs should be established at a University in order to:

1. preserve the status of qualifications presently obtained by dental hygienists.
2. maintain continuity between present training, retraining and degree program.
3. provide highly specialized facilities, equipment and staff already at the university.
4. strengthen the team approach of dentistry by close contact with the Faculty of Dentistry.
5. provide an opportunity to experience all aspects of dental science.

Proposals have been made to introduce a new auxiliary in the dental profession to deliver restorative procedures.

A graduate hygienist is at an advantage to expand her duties over any other auxiliary for the following reasons:

1. She has the academic background in the basic and dental sciences
2. She has developed the manual dexterity from previous training and experience
3. She is clinically oriented as she has worked on a number of patients while at university and after graduation

In addition to producing the necessary skilled and knowledgeable auxiliary, there is also a need for a **provincial agency** specialized in designing and supplying educational materials. Perhaps a **consultant** could be incorporated into this agency, preferably a dental hygienist with experience and qualification to act as an advisor. Also, with the advent of different levels of trained hygienists, we feel that **regionalization** would efficiently utilize the specialized skills and responsibilities of each auxiliary.

In summary, public health dental hygienists feel they can give a better service to the public through expanded duties (restorative procedures) as an adjunct to their present role in the prevention of disease and maintenance of good oral health.

LUST CONTROL OR PREVENTION AND TREATMENT OF THE OFFENSIVELY AMOROUS PATIENT

by
Barbara Rogers, R.D.H.

*Reprinted from San Fernando Valley Dental Society Bulletin, November
Pages 34 and 35*

"He is more to be pitied than censured, he is more to be helped than despised"—the unfortunate male patient who uses offensive behavior to compensate for fear and feelings of inadequacy. The skillful hygienist, using sensitivity as well as appropriate techniques of prevention and treatment, can successfully minimize embarrassing situations, maintain office routine and good will, and give the patient a feeling of self-respect.

Before proceeding with the techniques helpful in handling this type of patient, it should be emphasized that the following personalities are not included in this discussion:

a. The nice man who makes your day by giving you an approving glance, or by saying that you have beautiful eyes, etc., and leaves it at that.

b. The sweet old man of 75 or over who tells you an off-color story not to shock you but to let you know there is still some blood flowing in his veins.

c. The mentally retarded man/boy who sincerely honors you with a hug or kiss because you have earned his trust.

3. Give your best efforts to every patient. Be well-informed and interested in your work. Patients have respect for your standards and enthusiasm.

4. Make sure the patient is aware that you are concerned about his comfort and welfare.

5. Look at each patient's record before you start to work. You should be knowledgeable about his dental history, as well as his marital status and occupation. Comments made by the previous hygienist may also be helpful, since forewarned is forearmed!

6. Do not work on a new patient when alone in the office.

7. If the patient appears to be under the influence of alcohol or drugs, check with the doctor before proceeding.

8. Do not lean over the patient while adjusting your handpiece.

9. Do not show boredom, complain about your boyfriend, husband, or kids, mention that you are working because you need the money. The type of patient we are concerned with may take what you say as a cue that he is just what you need!

SUGGESTED TREATMENT

When the patient doesn't "get the message" through preventive techniques, the methods described below may be useful, depending of course, upon the patient, the hygienist, and the situation.

The hand dangler, the fanny pincher, the leg-grabber, the bosom bumper must be stopped immediately, for his safety as well as yours!

PREVENTIVE TECHNIQUES

Please note that many of these suggestions are or should be part of general office procedures.

1. You and your operatory should always be neat, clean, and appropriately decorated.

2. Always be tactful, pleasant, poised, considerate, and above all, professional when dealing with patients.

Recommended procedure: Making sure that your voice and facial expression give the impression the incident was accidental (could be); excuse yourself, thereby letting the patient think that you think you did the bumping. (Still with me?). Continue by saying you realize the dental chair is not very comfortable, but you would appreciate it if he would sit as quietly as possible and keep his hands in his lap, because any sudden or unexpected movement might cause your VERY SHARP instruments to SLIP and SERIOUSLY INJURE him (emphasis intended.) Your candor, "cool," and concern should prevent a reoccurrence. If not, use karate or have him rinse his mouth with Phisohex.

Now, on to the "dirty mouth," the improper propositioner, the leerer, and the double entendre smirker—easy ones to deal with compared to the gem described above.

Keeping your perspective and sense of humor, use the following, as needed:

1. Always keep working.
2. Play deaf, as well as mute, and refuse to react.
3. Be serious, slightly aloof, and very earnest. After all, a woman dedicated to dental floss and toothbrushes is not quite what this guy has in mind.
4. Give him the "look," a combination of amused tolerance, growing disdain, and martyred patience.
5. Ask him how his wife and kids are—a sure trick to arouse pride, guilt, or both.
6. Break your silence to seriously tell him, "Considering your age, your gums are in pretty good condition." This is a devastating but gentle put-down for the over forty adventurer.
7. Talk, talk, talk while you work, work, work—about your boyfriend, husband, kids, furniture, your mother, clothes, your household help, etc. This turn-off is so effective that the patient behaves perfectly so that you will finish in a hurry and he can escape!

8. Ask his advice on something you want to get for your boyfriend or husband. This effectively kills two birds because he knows you are devoted to your husband, etc., and he is thrilled that you asked for his opinion.

In conclusion, it is well to remember that the "problem" patient is a very sensitive human being who is entitled to the same high quality of care given to the normal majority of patients. A skillful hygienist is often instrumental in turning the "office problem" into a loyal, respectful, and favored patient.

DR. NIZEL RECEIVES GRANT

BOSTON— Dr. Abraham E. Nizel, Associate Professor of Social Dentistry (Nutrition) at Tufts University School of Dental Medicine, is the recipient of a \$9,000 research grant from the National Dairy Council in Chicago. This award supplements earlier grants over the past five years of \$40,000 from this foundation and \$95,000 from the Nutrition Foundation (New York). The major objective of this research was to develop a unique model nutrition teaching program for dentists, dental hygienists and nutritionists who wish to expand their knowledge in the science and practice of dental nutrition.

This first-in-the nation program has been concerned with:

- presenting to pre-and postdoctoral dental students the science and practice of nutrition as it applies to clinical dentistry with emphasis on its contribution to prevention. Dental students are being taught how to provide personalized non-directive diet counseling and furthermore are being made to realize that this is as definitive a dental service as are dental x-rays or dental restorations;
- teaching dental hygiene students how they can expand their responsibilities and duties in preventive dentistry by including a diet counseling service;
- teaching nutritionists how they can function as consultants for the dental practitioner as they do for the physician;

providing a dental nutrition teaching program for other dental schools and schools of dental hygiene. To date through workshops and summer courses, 60 dental hygiene professors and 10 dental school professors from 30 states have been acquainted with the innovative Tufts approach to teaching nutrition.

Since the dental health team probably sees patients more frequently and more regularly than any other health professional including the physician, they have a unique opportunity to provide authoritative, relevant dietary information. They, further, can combat food myths and "health" food misinformation widely propagated by other media, according to Dr. Nizel.

Even though prevention in dentistry is by no means a new philosophy, making it a definitive practical objective office procedure is new. Diet counseling is one of these new procedures.

Dr. Nizel is the author of **Nutrition in Preventive Dentistry: Science and Practice**, a recently (January 1972) published 500-page comprehensive clinical guide to preventive dentistry based on the latest proven nutritional concepts. In this text, Dr. Nizel stresses that the aphorism of "brush after every meal" is no longer the only preventive advice the dentist can give his patients.

Abraham E. Nizel, D.M.D., M.S.D., is Associate Professor of Nutrition at Tufts University School of Dental Medicine; Visiting Associate Professor of Nutrition and Metabolism at M.I.T.; and Lecturer in Nutrition, Forsyth Dental Center, School of Dental Hygiene. Dr. Nizel is married and resides at 537 Parker St. in Newton Center.

WORKING ON THE NUTRITION CANADA SURVEY AS A DENTAL HYGIENIST

This report was written by Miss Gladys Syrynk, a hygienist who graduated from the University of Manitoba in 1970. After working in a private clinic practice for nine months, she joined the Nutrition Canada Survey and has been with them ever since, working and travelling across Canada wherever the survey takes her.

In November, 1969, the Honourable John Munro, Minister of National Health and Welfare, announced the plans for a National Nutrition survey of Canada. The actual survey began in October, 1970, and will continue for another two years. The survey consists of four basic components: Nutrition, Clinical, Dental, and Biochemical.

Since May of 1971, I have had the opportunity, as a dental hygienist, to be part of the national Nutrition Canada survey, along with twenty other team members, combing the country on a fact-finding mission to find out if Canadians are generally well fed. The survey sample includes 21,000 people in 400 enumeration areas, 2,500 Indians on 30 reservations, and 800 residents (Eskimo and white populations) of four Eskimo communities. This summer, transient youth will also be surveyed.

An equal number of people are selected from each of five geographic survey regions: Atlantic, Quebec, Ontario, Prairies and Pacific. Each region is done twice in fluctuating seasons as food habits change. The purpose of the national nutrition survey is to provide information on the nutritional well-being of Canadians for planning of public health programs and for developing food legislation.

What is my job all about? The dental section consists of an examiner, myself, and a recording clerk. Partly by questioning, but mainly by examining, data is recorded on some forty aspects of dental health. The dental equipment provided is that which is essential for a limited clinical examination conducted with a mouth mirror and explorer, along with a portable dental chair and examining light.

The examination of the Nutrition Canada dental section differs in purpose and detail recorded from a clinical examination given by a dentist. A dental examination which a private patient receives encompasses the entire oral cavity and is concentrated on those details which determine the current treatment needs. The survey dental examination records data which reflects the history of nutritional, genetic, and disease factors as well as signs of current conditions. A second difference is that the survey dental examination is concentrated mainly on teeth and their immediately associated tissues. The rest of the mouth, the tongue, cheeks, and so forth are the responsibility of the medical examiner.

The examination in brief consists of questions and observations regarding:

- last dental visits and reasons
- ability in biting and chewing
- denture history
- number of deciduous and permanent teeth
- gingival and periodontal conditions
- cleft lip and palate
- height of soft debris and calculus
- Treatment status as to number of restorations and extractions
- degree of enamel hypoplasia or mottling
- presence of orthodontic appliances, space maintainers, partial dentures, bridges
- determining posterior occlusion and crossbites, and measuring overjet, underjet, openbite, or overbite
- lastly, DMF

I feel that a distinguishable feature about my job is public relations. The dental examination methodology is designed to produce six complete examinations every fifty minutes. Within four 2-hour sessions I meet on the average 48 participants from all walks of life and all age groups from a one-month old baby to a 103 year old lady. The people are also from various regions including both rural and urban. One can notice differing attitudes among different cultural groups. Of particular interest to me were the survey of the Indian, Chinese, Portuguese, and Hutterite populations.

In the past months I have come across many unusual cases and dental histories as inlaid dentures, clefts, transplants, are something like a husband wearing his wife's dentures.

One of the most interesting aspects of a large scale survey is the opportunity it affords to seek correlations between the factors assessed and the dental conditions of groups. Two nutritionally related factors that have a very direct effect upon the health of the teeth are specific quantities of fluoride in the drinking water and the frequency with which certain carbohydrates, principally sucrose, are consumed. In the Nutrition Canada Survey the nutritionists record the frequency of food and beverage intake. This data will be correlated with records of clinical conditions. What a marvellous bonus if some new relationships become evident when the nutrition survey data is analyzed.

My job with the Nutrition Canada Survey has been somewhat different from working in a private dental office or public health. Almost every day our clinic is set up in a different site in a different town and this prevents monotony. The clinic sites are usually schools, churches, or halls. Just recently we spent four days working in a federal penitentiary in Abbotsford, B.C. We work on the average of three to four days a week, and the remaining days are travel days. The hours are long, from 1 p.m. to 10 p.m., or longer,

depending on the travel involved. Working in close contact with nurses, nutritionists, and medical technologists is interesting, as one can learn about other related health professions.

Thus far I have travelled throughout the prairies and B.C. and have been able to get a general idea of how dental health varies across the country. It is obvious there is a definite need for better dental care and dental health education. In talking to different dental health directors, the need and demand for dental hygienists is evident.

Having graduated just two years ago my dental hygiene career has proved very exciting. Working with the survey is a great way to see and know Canada. The total experience has been most rewarding.

POSITIONS AVAILABLE

Dental Hygienist: Full-time position, shared between periodontist and general practitioner. Concentration on preventive and crown and bridge restorative practices, university teaching. Excellent office conditions—separate operatory, fully equipped. Bilingual ability an asset, but not essential. Serious applicants for long-term employment will be considered.

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